BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
EDWARD MANOUGIAN, M.D.	)	Case No. 12-2007-187981
Physician's and Surgeon's Certificate No. C-17929	)	OAH No. 2011110088
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 12, 2012.

IT IS SO ORDERED September 14, 2012.

MEDICAL BOARD OF CALIFORNIA

By: Reginald Low MD
Reginald Low, M.D., Chair
Panel B

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PROPOSED DECISION

Administrative Law Judge Mary-Margaret Anderson, Office of Administrative Hearings, State of California, heard this matter on January 23 through 27, and 30, and March 12 through 16, 19, 20 and 22, 2012, in Oakland, California.

Brenda P. Reyes, Deputy Attorney General, and Lynne K. Dombrowski, Deputy Attorney General, represented Complainant Linda K. Whitney, Executive Director of the Medical Board of California.

Marvin Firestone, M.D., Attorney at Law, represented Respondent Edward Manougian, M.D., who was present.

The record was left open at the parties' request to allow them to file written closing argument. The briefs were timely received and marked for identification as follows: Complainant's Closing Argument is Exhibit 70, Respondent's Reply to Complainant's Closing Argument is Exhibit X, and Complainant's Objections to Evidence and Motion to Strike and Reply Closing Argument is Exhibit 71.[1]

[1] Respondent attached a document to his closing brief that he marked as Exhibit X, and made reference to the document and to portions of the Federal Register in his brief. Complainant objects to both. Respondent did not move admission of an additional document; he merely attached it to his brief. As the briefs are marked for identification only, the document is not received in evidence. As regards references to it and to the Federal Register in the brief. Again, the brief is not evidence, it is argument. Therefore, no remedy or ruling is required to protect the evidentiary record and Complainant's Motion to Strike is denied.

The record closed on May 15, 2012.

FACTUAL FINDINGS

1. Complainant Linda K. Whitney issued the Second Amended Accusation in her official capacity as Executive Director of the Medical Board of California (Board).

2. On August 16, 1956, the Board issued Physician's and Surgeon's Certificate No. C 17929 to Edward Manougian, M.D. (Respondent). Respondent's certificate will expire on April 30, 2013, unless renewed.

Interim Suspension Order

3. On April 5, 2011, pursuant to Government Code section 11529, a Conditional Interim Order of Suspension (ISO), was issued against Respondent. It was based upon findings that his prescribing practices represented a clear and present danger to the public, and that his continued prescribing would endanger the public health, safety, or welfare. The suspension was stayed on the condition that Respondent refrain from possessing, prescribing, dispensing, furnishing, administering or otherwise distributing, any controlled substance or any dangerous drug. In addition, he was ordered to surrender to the Board any controlled substance prescriptions forms (triplicates), Drug Enforcement Administration (DEA) Drug Order Forms, and all DEA permits.

Accusation

4. In a Second Amended Accusation signed January 9, 2012, Complainant alleges unprofessional conduct by Respondent in the medical care and treatment of eleven patients he treated for chronic pain, principally in his solo practice. Although the facts differ somewhat among the patients, the allegations include that he was grossly negligent and/or incompetent, and/or committed repeated negligent acts, by virtue of prescribing controlled substances and dangerous drugs without appropriate prior examinations and medical indication; failing to obtain and document informed consent; failing to adequately assess the psychological functioning of patients; failing to conduct periodic reviews of patients, such as by obtaining random urine screens and/or a Controlled Utilization Review and Evaluation System (CURES) patient activity report; failing to consider referring patients to another pain specialist and/or failure to consult with another pain specialist; diagnosis of conditions without objective findings to support the diagnosis; and failing to properly document treatment plans. Complainant also alleges unprofessional conduct by excessive prescribing, as regards his prescriptions for Phenergan with codeine cough syrup (PCCS), and because the amount of acetaminophen he prescribed at times reached toxic levels.

Complainant also charged Respondent with inadequate record-keeping. And, it is alleged that he violated the ISO because prescriptions carrying dates later than April 5, 2011, were presented to pharmacies to be filled.

5. The standard of proof applied in making the Factual Findings in this matter is clear and convincing evidence to a reasonable certainty.

Relevant medications

6. The medications prescribed by Respondent during the time period addressed herein include the following controlled substances and/or dangerous drugs:

a. Ativan, a trade name for lorazepam, is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and section 1308.14 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

b. Dilaudid, a trade name for hydromorphone hydrochloride, is a Schedule II controlled substance as defined by section 11055, subdivision (d), of the Health and Safety Code, and section 1308.12 (d) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

c. Fentanyl is an opioid analgesic. Duragesic is a trade name for a fentanyl transdermal system. Fentanyl is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code, and section 1308.12 (d) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

d. Methadone hydrochloride is a synthetic narcotic analgesic. It is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c), of the Health and Safety Code, and section 1308.12 (c) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

e. Norco is a trade name for hydrocodone bitartrate with acetaminophen. Hydrocodone bitartrate is a semi-synthetic narcotic analgesic. It is a Schedule III controlled substance as defined by section 11056, subdivision (e), of the Health and Safety Code, and section 1308.13 (e) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

f. OxyContin is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is derived from an opium alkaloid. OxyContin is a Schedule II controlled substance as defined by section 11055, subdivision (b)(1), of the Health and Safety Code, and section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

g. Percocet is a trade name for a combination of oxycodone hydrochloride and acetaminophen. It is a semi-synthetic narcotic analgesic. Percocet is a Schedule II controlled substance as defined by section 11055, subdivision (b)(1)(N), of the Health and Safety Code,

and section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

h. Phenergan is a trade name for promethazine HCl. It is a Schedule V controlled substance under Health and Safety Code section 11058 and section 1308.15 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

i. Phenergan (promethazine) with codeine cough syrup is a Schedule V controlled substance under Health and Safety Code section 11058 and section 1308.15 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

j. Roxicet is a trade name for a combination of oxycodone hydrochloride and acetaminophen, a semi-synthetic narcotic analgesic. It is a Schedule II controlled substance and narcotic under Health and Safety Code section 11055, subdivision (b)(1), and section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

k. Soma is a trade name for carisoprodol tablets. Carisoprodol is a muscle-relaxant and sedative. It is a Schedule III controlled substance under Health and Safety Code section 11056, subdivision (e), and section 1308.13 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

l. Valium is a trade name for diazepam, a psychotropic drug. It is a Schedule IV controlled substance under Health and Safety Code section 11057 and section 1308.14 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

m. Vicodin ES is a trade name for a combination of hydrocodone bitartrate and acetaminophen and is a semi-synthetic narcotic analgesic. It is a Schedule III controlled substance and narcotic under Health and Safety Code section 11056, subdivision (e), and section 1308.13(e) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

n. Xanax is a trade name for alprazolam tablets. Alprazolam is a psychotropic triazolo analogue of the benzodiazepine class of central nervous system-active compounds. It is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d), and section 1308.14(c) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

Respondent's education and background

7. Respondent was first licensed to practice medicine in California in 1956. He has never been sued for malpractice or previously been the subject of a Board accusation.

Respondent is not board certified in any practice area and has never had hospital privileges, although he has served on hospital staffs. Beginning in 2007, and until the ISO was issued, he was conducting a part-time, solo practice confined to the treatment of patients reporting intractable pain and who he identified as suffering from chronic pain syndrome.

8. Respondent graduated from the University of Michigan Medical School in 1955. He completed a one-year rotating internship at San Bernardino County Charity Hospital. Respondent did not enter a residency program. He subsequently worked as a staff physician at Patton State Hospital, a psychiatric facility. Respondent joined the United States Army Reserve, and was called to serve in Korea. After he returned in 1962, he received a two-year fellowship from the National Institute of Health, and engaged in clinical work and research at the University of California at Berkeley. The research included new procedures for the treatment of breast cancer and diabetic retinopathy. Respondent worked at the university until 1977, but he also would, from time to time, cover for doctors who were on vacation. From 1978 to 1981, Respondent worked at Peralta Hospital, in emergency care and as the medical director of an alcohol detoxification program.

In 1982, Respondent began working with the Hospice of Contra Costa, which was affiliated with John Muir Medical Center. This work mainly involved palliative care for cancer patients. His function was to admit patients to the program, take a history and physical from them, and otherwise support their care in a home setting. The primary pain medication used was morphine.

Also in 1982, Respondent rejoined the Army Reserve and conducted research at Letterman Hospital until it closed. Projects included research on the eye and how photo-resection occurs. Respondent was called up for the first Gulf War, and spent 1990 to 1991 in Fort Bragg, North Carolina. He departed the military with the rank of Lieutenant Colonel.

9. Throughout most of his medical career, Respondent worked concurrently in a variety of different positions. At one point, he held seven different positions, including conducting physical examinations for a local police department and admitting psychiatric patients (conducting their medical evaluations) to a hospital. In 1992, Respondent ceased hospice work. His resume states as follows for the period 1993-2005: "Admission physical examination of psychiatric patients admitted to the outpatient psychiatric service at Alameda County Medical Center with consultation regarding their medical infirmaries." Also in 1993, he began performing evaluations for the California Department of Rehabilitation (CDR), approximately five hours per week.

Respondent's practice 2003 to 2011

10. In 2003, Respondent answered an advertisement for a contract physician to work at the Redwood Rehabilitation Medical Group, Inc. (Redwood). The Redwood practice was limited to occupational medicine for industrial injuries. Respondent worked about 16 hours a week. The patients he saw generally had workers' compensation cases pending. Many of them

had chronic pain problems that were difficult to treat. In 2005, the practice was sold and began operating as Advanced Pain Management and Rehabilitation Medical Group (APMR). The new owners moved the practice to a location that was inconvenient for Respondent. In addition, Respondent did not care for an electronic records service that was implemented. He therefore began looking for an office that he could afford to operate on his own.

11. Respondent opened an office in Hercules in August of 2007. He had billed others for work performed in the past, so had been self-employed, but had never before set up a practice where he saw patients. Some patients followed him from APMR. Respondent limited his practice to treating patients he identified as suffering from chronic pain syndrome. He made this decision in part because other doctors "often will not treat it." He served many indigent patients who had no private health insurance.

12. After the ISO was issued, Respondent could no longer operate his pain management practice because of the inability to prescribe. He has continued to work for the CDR as a permanent intermittent employee, approximately 112 hours per month, or the equivalent of three days per week. The CDR position does not include seeing patients or prescribing.

- general views regarding treatment for chronic pain

13. Respondent has not engaged in a formal course of study as regards the treatment of pain or pain management. His formal post-graduate education in pain management is confined to the mandatory courses required of all physicians. And he has no special training or experience in addiction medicine or rehabilitation from drugs, notwithstanding having medically evaluated patients entering alcohol detoxification programs. He is not a member of any pain-related professional organizations, although he claims to receive literature from them. When he began work at Redwood, his experience with pain patients was apparently confined to prescribing morphine in a hospice setting for the pain experienced at the end of life. But it is clear that he has read extensively on the subject of chronic pain and the use of medications to treat it, and has formed many opinions.

14. In connection with his work for the CDR, Respondent was asked to write an update for information their library provided on chronic pain. The update discussed the "pain related nerve system." The sympathetic nervous system, he explained, "acts up, and affects lots of things." The continual pain "causes genetic changes in the nervous system pathways." Respondent created a drawing, the "Pathophysiology of Pain Chart," which he used with patients (and at hearing) to illustrate his opinions. He described chronic pain syndrome as "the exhaustion stage of general adaptation syndrome." Respondent's studies led him to conclude that higher doses of opiates were needed to treat the patients he sees, because of this "exhaustion factor." He accordingly developed a regimen of short-term and long-term acting drugs, and prescribed them in high doses, along with other medications, such as a narcotic generally prescribed for coughs, and anti-depressants that relieve pain when combined with certain opiates. Respondent describes this treatment method as "pain polypharmacy," and along

with recommendations for certain exercises designed to provide a "boost to the endorphin system," it constitutes what he calls his program.

15. Respondent diagnosed each of the eleven patients in this matter with chronic pain syndrome and he treated each of them with a version of his program. Respondent clearly believes that his program is essential for the treatment of chronic pain and can result in a cure. He compared his program to a diabetes program that includes taking insulin.

Office procedures 2007-2011

16. Respondent worked one or two days a week in his private pain management practice. He did not have an answering service, and no other doctor took call for him. He accepted cash only; he did not accept Medi-Cal or insurance payments. Respondent charged $300 for an initial visit (which lasted one hour) and then $100 per visit (lasting 20 minutes). Generally, he saw his patients once a month. Respondent provided information to patients about filling prescriptions he issued, including suggestions for utilizing insurance. Respondent also issued sequential prescriptions, which he would post-date in 30-day intervals for a total of 90 days. If he wrote sequential prescriptions, he would see the patient every 12 weeks, instead of every four.

17. Respondent has given different explanations of his charges for the visits that included the issuance of sequential prescriptions. On March 30, 2010, prior to the filing of the initial Accusation, he was interviewed by Board staff. Respondent stated that he charged $200 for the visits where sequential prescriptions were issued, but did nothing else differently. He pointed out that patients would save money, as it was like having three visits for the price of two. In his testimony, Respondent acknowledged that his practice and method of issuing Post-dated prescriptions were unlawful. He was unaware at the time of the applicable laws and regulations.

18. Respondent asserts that he always ordered a new patient's medical records, but did not wait to receive them before treating the patient. He would ask the patient to tell him "where it hurts," and he then examined that area. He did not take blood pressure readings unless he felt he needed to. He did not weigh or measure patients. When a patient told him that he or she was taking or had taken a particular medication, he believed the statements. Respondent claimed that he gave each patient exercises to do, but he did not, however, routinely reference the exercise portion of his program in the patient's chart.

-informed consent

19. Respondent testified that the purpose of informed consent is to inform the patient of side effects, risks and benefits, and the "limitations of my therapy." He contends that the requirements for informed consent were satisfied by the discussions he had with patients, and the three forms he utilized. The first form is a "Welcome Letter." It reads:

WELCOME to the office of Edward Manougian, M.D., for chronic pain management. Certification of a chronic pain condition is necessary for treatment in this office. To facilitate the process of certification, please bring all pertinent medical records you have in your possession.

It is expected that you have one of the following conditions:

(1) Persistent severe pain, that is, pain at a level of 5 to 10 on the usual 0-10 scale, for at least 3 months.
(2) Persistent moderate pain, that is, pain at level 2 or above on the 0-10 scale, for at least 6 months.
(3) Intermittent severe pain enough to prevent you from performing your activities, such as migraine headaches.

This program only relies on oral medications. The goal is to enable persons to return to a productive life. At other medical facilities, medications may be administrated by routes other than oral. This includes injections of various types, for example, intravenous injection, epidural block, sympathetic block, peripheral nerve block, intrathecal injection.

Many other forms of pain management exist, most of which are complementary to oral medication. Examples are surgery, acupuncture, physical therapy, chiropractic, electrical stimulation, magnetic field stimulation, acupressure, massage, heat, cold compresses, balms, medical devices, traction, etc.

Persons coming to this office are expected to have undergone some of the therapies listed.

_____ _____

Signature Date

On the Welcome Letter exemplar that Respondent submitted in evidence, the words "Signature" and "Date" are handwritten.

20. The second form is entitled Patient Testimonial, and it is utilized to monitor a patient's progress. The form asks questions about pain control, and increases in physical and social activity. It asks the patient to circle a number indicating the percentage improvement in each of those areas. It also asks the patient to indicate "true" or "false" next to four statements:

I am the **only person** who uses the medications prescribed for me by Dr. Manougian

I do **not give or sell** any of the medications prescribed for me by Dr. Manougian

I **sometimes** give some of my medications to relatives, friends, or others who are in pain

I **have not obtained medications** for my **pain** from any source other than Dr. Manougian

[Emphasis in original.]

21. The third "form" is actually two pages of information about Respondent's practice. One is entitled "Policy Regarding Medications," and gives options for obtaining medications from pharmacies, including that the patient may pay cash. It also gives information about how to work with insurance companies and how to apply directly to manufacturers by utilizing patient assistance programs. There is no information about the medications themselves.

The second page is entitled "Notice," and states "The method of treatment in this office is based on medication. The disease treated in this office is 'Chronic Pain Syndrome.'" Following is a long list of the medications that might be prescribed. There is no other information about the medications. There follows more information about insurance, and other ways to fill prescriptions, as well as Respondent's payment policies.

22. It remains unclear how the identified forms could qualify as providing informed consent. Respondent testified, somewhat inconsistently, that he warned his patients about taking an excess of acetaminophen, including by use of the forms, but none of the documents address that topic. He testified that he also orally warned patients about taking over-the-counter medications containing acetaminophen when taking prescribed medications that contain that ingredient. But there was no documentation in the medical records to support this testimony. And, as is discussed further below, Respondent in general expressed disbelief that his patients, who were the opposite of opiate naïve, were in real danger of liver damage from acetaminophen toxicity.

-lab test policies

23. At a Board interview on April 27, 2010, Respondent stated that he ordered tests to check liver function, kidney function, and blood counts "routinely, every six months to maybe every year." He then stated that he did not enforce obtaining this lab work, because most of his patients did not "live normal lives" or have health insurance so he had "to make do with what I can." When asked why he would order the tests if they were not really needed, he did not reply, and insisted that the drugs he prescribed were "perfectly safe."

24. It appears that testing was done on a routine basis at Redwood and APMS. This was not the case in Respondent's solo practice, however, as is further revealed below as regards the individual patients.

25. As to toxicology screenings, at a Board interview on July 9, 2008, Respondent stated that he saw no benefit in such testing. When asked what the results of a toxicology screen would provide, Respondent answered "Nothing of significance to me." He explained that if, for example, a test revealed a patient was using cocaine, this would be Respondent's fault, because he had not adequately treated the patient's pain. And he believed that the chance would be "almost zero" that the results would show that the patient was not taking what Respondent had prescribed.

26. Respondent expressed complete confidence that if a patient was selling the medications that Respondent prescribed, the patient would tell him. He worked hard at developing rapport with his patients, and once rapport was established, Respondent believed his patients "without question."

-policies for lost or stolen prescriptions

27. Respondent has maintained that he employed a "three strikes" policy for lost or stolen prescriptions. That is, after three times, he would tell a patient that he or she would not receive replacements. He also stated that the policy was not followed, however, for certain patients in difficult circumstances; for example, if they were confined to wheelchairs, or had chaotic living situations. If a patient told him that a prescription had been stolen, Respondent's policy also required the patient to make a police report and provide it to him. He did not always adhere to this policy either.

Initial basis for investigation: complaints from pharmacists

28. Beginning in November 2007, the Board received complaints from pharmacists concerning Respondent's prescribing practices. Noelle Holloway, a Board investigator, conducted three investigations concerning Respondent. The first was generated by a report from David M. Ash, a pharmacist with White Cross Professional Pharmacy in Pinole, and concerned prescriptions for two patients: DS and GB.[2] Holloway obtained a CURES report for each patient. CURES reports are compiled by the Bureau of Enforcement of the California Department of Justice. They contain information obtained from pharmacists and dispensing physicians regarding prescriptions for Schedule II, III and IV drugs. The purpose of the CURES database is to provide information to health care providers and law enforcement. The reports reveal what a physician is prescribing, what a patient is receiving, the quantity, and which pharmacy was used. Holloway also obtains patient prescription profiles directly from pharmacies in connection with her investigations. These may reveal non-scheduled drugs that a patient is receiving that are not contained in CURES reports.

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[2] Patients are identified by initials to protect privacy.

29. Pharmacist Ash wrote that he "felt it necessary to report" Respondent because of prescriptions written for DS and GB. He wrote "as you can see he has prescribed excessive dosages for the given drugs, plus excessive amounts of the drugs for a month's use and excessive combinations of the drugs." When Ash called Respondent to ask for information regarding the prescriptions, Respondent accused Ash of "not understanding pain management."

30. On August 18, 2008, Rose Gin, a licensed pharmacist since 1974, filed a complaint form concerning Respondent with the Board. She was working at a Safeway pharmacy in San Lorenzo at the time. In the Details section, Gin wrote:

> Physician is prescribing excessive amounts of controlled substances to patients without regards to their age; i.e. #400 Vicodin ES to be taken 3 tablets every 4 hours around the clock, 3 to 4 bottles of Phenergan with Codeine (64 ounces) to be taken 2 to 3 teaspoonfuls every 4 hours as needed for sleep around the clock, #240 Valium 10 g to be taken 4 times daily while awake and as needed at night to help with anxiety and sleep. All of the above to be refilled every 20 days or earlier if needed by customer.
>
> [¶] . . . [¶]
>
> He always sends a note for the Pharmacist to release medications early, i.e. after 10 days because the customer seem[ed] to have lost the drugs or the drugs are stolen. The customer will then pay cash for a duplication of all the medications filled prior.
>
> This type of practice should be investigate[d] before a fatality occurs. Why are all the customers getting the same medications with the same directions that are excessive? Why are there 3 refills on all the medications? Why are they always lost or stolen after 1 week or so?

31. Gin dispensed medications to Respondent's patients for about two months before she recognized a pattern. She understood that Respondent was treating chronic pain patients, but was alarmed because of the amounts and types of drugs prescribed, and the surrounding circumstances. Gin called Respondent to tell him that she was not comfortable dispensing "the huge quantities." She made a second call to say that she was not comfortable with early refills, when she saw a pattern of "all of his patients losing their prescriptions." This prompted worries about drug diversion. She was also concerned about the possible effects on the liver from large doses of acetaminophen, having learned in pharmacy school of the risks. Respondent told her to leave the doctoring to him. Gin explained, however, that it is one of her responsibilities as a licensed pharmacist to explain the effects of drug interactions to customers. Gin decided to stop filling prescriptions for Respondent's patients.

32. The third investigation was prompted by a report from the Director of Compliance at Longs Drug Store about patient IG. Holloway was assigned that matter on January 29, 2009, and proceeded to obtain CURES reports concerning prescriptions issued to IG.

Post-Interim Suspension Order activity

33. After the ISO was issued on April 5, 2011, Holloway picked up Respondent's prescription pads from his office. She estimates she did this within seven to ten days afterwards. He had already mailed in his DEA certificate. Holloway subsequently obtained some updated CURES reports using Respondent's name. She also contacted approximately 12 pharmacies directly and asked if they had any prescriptions in their possession that were issued after April 5. She learned about two incidents.

a. A prescription from Respondent dated April 13, 2011, for #180 tablets of methadone 10 mg was filled by Medicap Pharmacy in Pleasanton on April 15, 2011.

b. Three prescriptions from Respondent dated April 15, 2011, for #300 Oxycontin 80 mg; #300 methadone 10 mg; and #300 Dilaudid 8 mg were filled by a Rite Aid Pharmacy in Antioch on April 20, 2011.

34. Respondent did not directly address these matters in his testimony. But it is reasonable to infer that the two incidents resulted from his admitted practice of not dating sequential prescriptions on the date he wrote them, but rather on the date that they could be filled. It was therefore not proven that Respondent willfully violated the ISO.

Expert opinion evidence

- Kurt V. Miller, M.D. (patients IG, KM, JD, WR, JS, RB, LR, LW, and DC)

35. Kurt V. Miller, M.D., is board certified in psychiatry and neurology. He maintains a private solo practice in Fresno, where he specializes in clinical neurology and chronic pain management. Dr. Miller attended Hahnemann University College of Medicine in Pennsylvania, graduating in 1985. He completed his medical degree at the University of California, Davis, in 1986, and a residency in neurology at Stanford University in 1989. He then was awarded a fellowship at the University of California, San Francisco, Pain Management Center, which he completed in 1991.

36. Dr. Miller authored two reports to the Board concerning Respondent. The first is dated November 18, 2010, and the second March 13, 2011. He also signed a declaration in support of the ISO on March 10, 2011, and testified extensively at hearing. In addition to his knowledge and experience, Dr. Miller's opinions are based upon the review of medical records of nine patients and related reports, Respondent's curriculum vitae, and transcripts of Respondent's Board interviews.

37. Dr. Miller opined that the standard of care for a physician treating a patient with controlled substances for pain requires that the physician perform and document a complete evaluation of the patient; formulate a treatment plan; provide informed consent; obtain a written agreement for treatment; and undertake periodic reviews. The reviews should include, at a minimum, random urine drug testing to demonstrate that the patient is taking the prescribed medications and that the patient's urine is free of other drugs and substances, and obtaining a CURES patient activity report to determine whether the patient is obtaining prescription drugs from other sources.

38. Dr. Miller opined that the diagnosis of chronic pain syndrome, although still in textbooks, has fallen from common use and is now archaic. Instead, a modern diagnosis will more specifically describe the pain; for example, as chronic painful peripheral neuropathy or chronic migraines. These are descriptive diagnoses that are useful in directing treatment. In assessing pain levels, the use of the 0-10 scale is only useful with the same patient over time. The report of a pain level of 9 or 10 from a patient who walked into the office and did not appear to be in excruciating pain was not sufficiently descriptive to be helpful in determining a diagnosis. The use of different adjectives, such as "sharp" or "exhausting," are more helpful. And if there is a great deal of emotional content to the pain, it is treated differently. Overall, it is important to note that chronic pain is persistent. It is rare for patients to heal completely, so time is spent to create reasonable expectations, such as a 50 percent improvement.

39. Asked to comment upon Respondent's Pathophysiology of Pain chart, Dr. Miller described it as "a supposition of how things might be." Further, "it doesn't represent any of the current science or knowledge of chronic pain." He explained that it is accepted by pain experts that opioids are reliable for acute and sub-acute pain, but they are a last resort medication for chronic pain. Experiments in the 1980's of doses of opioids with no maximum limit were tried, but failed.

40. The initial evaluation for a patient complaining of pain requires obtaining a good faith history and physical, including history of any substance abuse, as well as information about the pain complaint. A treatment plan is devised that is appropriate for the patient, and his or her individual circumstances including age, addiction history, and goals. Complex cases should be referred as appropriate, for example, to an interventional psychiatrist. When narcotics are prescribed, it is important to gradually go up the analgesic ladder. After prescribing, there should be periodic review that includes "serious thinking" about the case and urine screens. Opiates are a double-edged sword, and present many problems. It is important to document compliance, due to the risk of addiction, misuse, and diversion. Misuse is the most common; some patients take too much, because they want to be emotionally dulled and removed psychologically from their environment. There are better drugs and therapies for anxiety. The goal is for patients to feel well enough to go shopping, for example, not for them to "just take pills" to relax. Dr. Miller began random testing a decade ago, and found the results remarkable. Some of his patients would use half their prescription and sell the other half. Regular testing is now the standard of care for pain management patients.

41. Dr. Miller explained that the laws surrounding the prescription of narcotics and dangerous drugs are indicative of the threats they pose to the patient and to the public. Schedule II drugs are the most tightly controlled. Generally they are written for no more than 30 days. It can be appropriate in some instances to give more than one 30-day prescription to the patient at one time, but each prescription must be dated the date that it is written, and then given a different fill date. This may only be done for patients who are known and trustworthy. For some patients, the opposite is true, and they might be given a lesser amount and be seen more often. These patients include those who often lose their prescriptions or ask for early refills. Dr. Miller had never before heard of charging patients more for visits that include giving sequential prescriptions, and described that practice as presenting a moral and ethical dilemma. In his opinion, this would mean that patients are in essence paying for a visit that they do not receive, and that the doctor is behaving more like a drug dealer than a physician.

42. Dr. Miller opined that it is the standard of care to start with low doses of opiates and titrate gradually as needed. For OxyContin, for example, the dose should only increase in increments of 25 percent. Otherwise, it could not be determined what dosage amount was appropriate. The type of pain is also important. For example, opiates have not been shown to be effective for musculoskeletal pain. The standard of care for musculoskeletal pain would be to start with a non-opioid such as one of the anti-depressants, assuming that Tylenol has been tried.

43. Dr. Miller also opined concerning the collateral danger to the patient presented by Respondent's prescribing practices. In this regard, his testimony concerning patient LW (see Findings 201-216) is instructive. LW presented with a mental illness, and stated he was under the care of a psychiatrist and had been prescribed Seroquel. Respondent never contacted the psychiatrist. He prescribed LW a combination of narcotics and dangerous drugs. Dr. Miller explained "Usually, patients with psychosis are a danger to themselves typically because of impulsivity. The problem is you can't give these people medications they can impulsively kill themselves with. It's like handing them a loaded gun. So if you are going to treat them with medications like MS Contin, for example, which can kill you . . . If you take Valium, take a bottle full of those, you are dead. So you have to give them very short prescriptions, sometimes days." Respondent's care of LW caused "a danger to that patient, this is a doctor-induced danger to the patient."

44. Dr. Miller's overall opinion of Respondent's practice, based on his expertise and the material he reviewed, is contained in his declaration:

> I am of the opinion that [Respondent] has a dangerously limited understanding of pharmacology and that he has a dangerous pattern of prescribing narcotics indiscriminately. His "one size fits all" treatment approach fails to tailor the medications to address a patient's particular needs and constitutes a dangerous and extreme departure from the standard of care in each of the nine patient cases I reviewed. [Respondent] prescribes narcotics and other controlled substances in a uniform manner without

examining, investigating or evaluating the basis of a patient's pain, without objective findings or a differential diagnosis. He offers no medication management and appears to make no medical decisions that respond to a patient's unique symptoms and complaints.

45. Dr. Miller is an expert in the care of patients with chronic pain, and he meticulously reviewed and opined regarding the care given each of nine patients and whether it complied with the standard of care. Dr. Miller was clearly upset by the care Respondent gave these patients, and his testimony was at times more emotional than is generally experienced from expert witnesses. There was an excitable quality and he had to be reminded repeatedly to slow his rate of speech. Nonetheless, these factors did not negatively affect his credibility. His opinions were clear, factually based, and ultimately persuasive. His opinions identified acts or omissions as constituting negligence or gross negligence; that is, as simple or extreme departures from the standard of care. For all of these reasons, the Factual Findings are based upon Dr. Miller's opinions regarding the standard of care, negligence, gross negligence, and incompetence, as well as issues of inappropriate and excessive prescribing.

- Bill McCarberg, M.D. (patients GB and DS)

46. Bill McCarberg, M.D., is board certified in family medicine and geriatrics. He holds a certification in pain medicine from the American Academy of Pain Medicine. In 1984, Dr. McCarberg became the first director of the Chronic Pain Management Program at the Southern California Kaiser Permanente Medical Group (Kaiser), and served in that position until 2003. He stills sees patients 40 hours each week at the Kaiser Program, and approximately 30 percent of those patients are suffering from chronic pain. Dr. McCarberg attended medical school at Northwestern University, graduating in 1976. He completed an internship and a residency in family medicine at Highland Hospital in Rochester, New York in 1979. Dr. McCarberg has been licensed in California since 1982, and has practiced in the Kaiser system his entire career.

47. Dr. McCarberg's professional activities reflect his career-long interest in chronic pain management. He is a member of the International Association for the Study of Pain and the American Pain Society. He is one of the physicians who reviews certification applications for the American Academy of Pain Medicine. He attends that group's meeting every year, and designed and teaches the course it offers in safe opiate prescribing. Dr. McCarberg regularly reads three pain journals, and is extensively published. Since 1993, he has delivered more than 500 lectures on pain-related topics.

48. Dr. McCarberg reviewed Respondent's care of two patients, GB and DS, a married couple. He reviewed medical records, prescriptions and CURES reports, as well as the transcript of Respondent's board interview on July 9, 2008, and other documents. Dr. McCarberg pointed out that there is not a nationally recognized standard for pain management as there is, for example, for diabetes. The guidelines he used in his review included his own protocols and the principles set forth in the Intractable Pain Act (Pain Act), adopted by the

California legislature in 1994 (Bus. & Prof. Code, § 2241.5, subd. (c)). Dr. McCarberg authored a written report dated September 27, 2009, and testified at hearing.

49. In his review, Dr. McCarberg evaluated the care provided GB and DS in the seven areas identified by the Pain Act: patient evaluation, treatment plan, informed consent, periodic review, referral, documentation, and compliance with relevant law. He elaborated on the areas as follows. The evaluation depends on the presenting complaint, but includes a work-up to try to determine the cause of the pain. Information includes what has been done in the past, lab test results, imaging studies, the treatments given, and outcomes. The standard history and physical should include the social background of the patient and any history or risk of substance abuse. Second, once the problem has been identified, a plan should be arrived at, along with the expectations of what will occur. The patient is then told about the risks, benefits, and alternatives to the care options; this is informed consent. Unique in the pain management area is that the doctor must record informed consent of the patient before starting treatment. The review performed depends upon what is warranted by the underlying medical condition. The time frame might be weekly, or once or twice per year if the patient is stable and the medication amount relatively small. Doctors should refer patients for further evaluations when conditions are beyond what the practitioner can handle. These conditions might include when surgery or physical therapy is necessary, where behaviors are worrisome, where there is evidence of addiction or significant risk of addiction, or when there are other significant psychological issues. Every visit should be documented and an appropriately directed physical examination should be performed each visit. Last, unique again to pain management, special attention must be paid to the relevant law concerning the particular medication. For some medications, there must be a follow-up with the patient every three months.

50. Dr. McCarberg identified other areas that are unique to the management of chronic pain patients. First, it is not uncommon that a reason for the pain cannot be found, particularly if it is in the low back. The work-up can be very frustrating, and the result can be that patients have to learn to live with a certain amount of disability. Another is that patients with a history of substance abuse are more likely to develop chronic pain. They are more likely to put themselves at risk, and because of injury or accident may end up with intractable pain. If the practitioner is not on guard and is not monitoring the patient appropriately, the patient can misuse or divert the medication. Although patients must be relied upon in their reports of pain, this does not mean that doctors do not also exercise clinical judgment. Excessive prescribing (more than is needed) creates the opportunity to sell, lose, or give away medications to others. Doctors must prescribe as little medication as possible, and constantly monitor the patient's behavior. In this regard, Dr. McCarberg noted that there is no evidence that combining similar medications in the manner favored by Respondent is better than a single medication. Lastly, it is very common for patients to have psychological and emotional issues. They can develop depression and anxiety, and experience a variety of behavioral issues such as social withdrawal. These co-morbid conditions must also be treated, using the appropriate protocols.

51. Dr. McCarberg is an expert in the treatment of chronic pain and his opinions were very persuasive. He is highly knowledgeable as a result of not only his direct professional experience, but also his participation in professional organizations, teaching, and writing. His

explanations of his opinions were exceptionally clear and convincing. Further bolstering his opinions was his objectivity, which was evidenced by his testimony that in some respects Respondent did not violate the standard of care; some of the care he described as "exemplary"; but the failure of Respondent to recognize potentially lethal doses of acetaminophen and the "unconventional combinations" of high doses of medications prescribed resulted in his ultimate opinion that Respondent's care of GB and DS represented an extreme departure from the standard of care. His opinions identified acts or omissions as constituting negligence or gross negligence; that is, as simple or extreme departures from the standard of care. For all of these reasons, the Factual Findings are based on Dr. McCarberg's opinions regarding the standard of care, negligence, gross negligence, and incompetence, as well as issues of inappropriate and excessive prescribing.

- Bernard R. Wilcosky, Jr., M.D. (all eleven patients)

52. Bernard R. Wilcosky, Jr., M.D., is board certified in anesthesiology. While still in the Army and stationed at Letterman Hospital, he was tasked with building a pain clinic for the use of anesthesiology residents. Dr. Wilcosky resigned from the military in 1989, and went to work at Sequoia Hospital, where he spent 25 percent of his time in the operating room, and 75 percent practicing pain medicine. Approximately eight years ago, he ceased operating room work. Dr. Wilcosky estimates that only five percent of his patients are experiencing acute pain; the balance have chronic pain.

53. Dr. Wilcosky initially reviewed the care of patients IG, KM and JD. His review was subsequently expanded to include all eleven patients. He read all of the medical records of the patients, the Board's investigative report, Dr. Miller's declaration, and transcripts of both Board interviews of Respondent. He also spoke twice with Respondent. Dr. Wilcosky understood that Respondent's practice involved providing pain treatment services to a "very difficult patient population," primarily those who are indigent, have few resources and are uninsured. He also believed that the patients had no real alternatives to receiving treatment for their pain, and it was in that setting that Respondent treated the patients.

54. Dr. Wilcosky found no overt violations of the standard of care by Respondent in the treatment of any of the eleven patients, and often found the care delivered by Respondent to be good. His opinions were rendered less persuasive than the other doctors for several reasons. First, his credentials are not as extensive as those of Dr. Miller and Dr. McCarberg. Further, his basis of knowledge of Respondent's experience was incorrect. For example, he credited Respondent with "many, many years of experience." Certainly Respondent has been a physician for many years, but his experience in the field of chronic pain management is relatively brief.

55. Dr. Wilcosky thought that Respondent had drug rehabilitation or addiction treatment experience that he does not have. His assertion that there is a correlation between administering morphine to patients dying of cancer and treating chronic pain patients, so as to bootstrap more experience to Respondent's history, is not accepted. Dr. Wilcosky also noted extensively the socio-economic status of the patient population served by Respondent, which

leads to the concern that his opinions reflect the application of a different standard of care based upon such status. His description of Respondent's patients included that they had no other alternatives for their chronic pain or that the alternatives were not available to them for financial reasons. In fact, many of the patients also saw other physicians, including surgeons, who prescribed pain medications for them. Dr. Wilcosky appeared to be reaching beyond reason when he opined that Respondent's communications with his patients through the welcome letter and the testimonials qualified as informed consent.

56. In sum, Dr. Wilcosky appeared to defer to Respondent's methods out of respect for Respondent and his length of practice, as opposed to exercising independent judgment when rendering opinions regarding the treatment provided the individual patients. And his opinions as regards the care given the individual patients were in opposition to the more persuasive opinions of both Dr. Miller and Dr. McCarberg. For all of these reasons, his opinions were accorded negligible weight and are accordingly not reflected in the Factual Findings.

Expert opinion evidence: acetaminophen dosage

57. Neal L. Benowitz, M.D., is Chief of the Division of Clinical Pharmacology at the University of California, San Francisco. He is a professor of medicine, bioengineering and therapeutic sciences. He is a clinical pharmacologist, and also a clinical toxicologist, which involves the diagnosis and management of injuries caused by drugs or chemicals. The California Poison Control Center is part of the Division. Dr. Benowitz was board certified in internal medicine in 1984, in medical toxicology in 1991, and in clinical pharmacology in 1993. He is a recognized expert, particularly for his research on nicotine, and has served as a consultant to the federal Food and Drug Administration (FDA) for many years. Dr. Benowitz is extensively published, has lectured throughout the world, and has served as a consultant and member of dozens of professional organizations and commissions. Particularly relevant here is his service as chair of the Non-prescription Drug Advisory Committee of the FDA in 2009 and 2010. He did not render opinions as to whether the treatment of the eleven patients by Respondent was within the standard of care. He testified at hearing concerning two topics.

58. The first topic addressed by Dr. Benowitz concerned the FDA guideline that limits acetaminophen dosing to not more than four grams per day. The charge of the FDA is to provide conservative guidelines and point out important safety aspects of the use of a particular drug. The FDA warning as regards acetaminophen is grounded in concern that the general public is unaware that many over-the-counter medications contain acetaminophen, and that an excessive level can be reached if a person is taking prescription medications (such as opiate-acetaminophen combinations) that contain it as well.

Dr. Benowitz has been involved in the issue of acetaminophen toxicity for many years. It is the most common drug that the Poison Control Center is concerned with. He has a fund of general knowledge, and also searched the medical literature concerning the use of amounts in excess of four grams per day, and the phenomenon of auto-protection.

59. Dr. Benowitz first explained that a single dose of 10 to 15 grams of acetaminophen can cause serious liver damage, and that this fact is not in dispute. This is known as acute toxicity. Chronic toxicity refers to taking lower doses over time, such as for pain control. There are case reports that patients taking four grams or more per day may suffer liver damage.

This being said, it is also true that some people can tolerate large doses of acetaminophen without injurious effects. Dr. Benowitz described four studies that support this conclusion. He explained that with chronic use, auto-protection mechanisms can be generated. This is a form of tolerance. When a patient has been exposed to a drug over a long period of time, he can tolerate doses that would previously have caused liver damage. Similarly, when a patient takes opiates on a regular basis the effect gradually lessens, and a higher dose will be needed to obtain the same effect. For example, an advanced cancer patient may receive large doses of morphine with no side effects, where a similar dose would be lethal for another patient. One of the studies Dr. Benowitz reviewed concluded that a high percentage of the opioid-dependent people taking greater than five grams of acetaminophen a day had no evidence of liver damage. Nonetheless, there is individuality in every response to a drug. It is influenced by age, sex, genetics, and many other factors. For example, the maximum dose for patients with compromised livers is less than four grams a day.

Finally, Dr. Benowitz explained that the FDA recommendations are issued out of an abundance of caution. They operate for the benefit of the entire population and aim to protect the most sensitive patients. In that context, the current limit has been set by the FDA at four grams.

60. Dr. Miller opined that the standard of care for the prescription of acetaminophen is the same as the FDA warning – a maximum of four grams per day. This standard has been in place since the 1980's, and the FDA is actually considering lowering the amount. Although some people tolerate a higher than expected dosage, they are the exception, not the norm. It is important that patients and the public be informed and aware of the toxicity potential of acetaminophen. Excessive amounts have led to many deaths and liver transplants in the last decade; it is the most common cause for liver failure. Thus, informed consent is very important to obtain. Patients on fixed-dose analgesics must be explicitly advised and warned about taking over-the-counter medications that also contain acetaminophen. And patients who are prescribed amounts close to the maximum must be checked once or twice a year for liver function. Dr. Miller also discussed the general duty of physicians to always modulate risks for patients.

61. Dr. McCarberg opined that over four grams per day of acetaminophen violates the standard of care and is a hazardous dose, particularly for a patient with liver damage. He noted that some expert organizations recommend less than that. Dr. McCarberg also believes that it is unnecessary to give patients more than four grams per day, because large doses of the medications that contain acetaminophen are unnecessary. He also stated that he is not an expert in the area of acetaminophen toxicity.

62. Dr. Wilcosky does not agree that the standard of care requires no more than four grams of acetaminophen daily. He contends that the FDA's "black box warning" does not take into account that many patients had been on higher doses for some time prior to the issuance of the warning in 2010. To reduce the dosage to those patients might negatively impact them. Dr. Wilcosky opined that the clinician has discretion to exceed this amount so long as the safety of the patient is considered. The patient must be followed, and liver function tests performed when warranted. None of the literature he consulted, however, supported doses higher than four grams daily.

63. It is Respondent's opinion that because many of his patients had been taking acetaminophen for years, the phenomenon of auto-protection applied, and doses exceeding four grams per day were not dangerous for them. Respondent argued in his closing brief that he was mindful of the issue of acetaminophen toxicity, and that he utilized a method to calculate the amount of acetaminophen that would be tolerated by taking into consideration the patient's body weight. This contention is not supported by the evidentiary record. First, there is no evidence that weight is a factor for determining the toxicity level of acetaminophen in adults. Further, Respondent did not have a scale in his office, or weigh his patients. It does not appear in his documentation that he even noted their weight from self-report. Nor is there evidence in his documentation that he warned them about the risk of what he was prescribing, or that he warned them about taking over-the-counter medications that contained acetaminophen, or that he consistently monitored his patients by ordering liver function testing.

- conclusions

64. Acetaminophen can be toxic to the liver, causing liver damage and death. Doses over four grams daily are unsafe for the majority of patients. There are studies that indicate a higher dose will be safe for certain patients, but these are exceptions.

65. Dr. Benowitz's expertise as a toxicologist is unquestionable and his background information was instructive, but he did not opine as regards the standard of care. Dr. Miller rendered a strong, well-considered opinion that was consistent with Dr. McCarberg's and to some extent with Dr. Wilcosky's. Respondent's position, on the other hand, was self-serving and not supported by the evidence. After considering all the evidence, it is determined that the opinion shared by Dr. Miller and Dr. McCarberg is more persuasive, and that the standard of care for physicians prescribing acetaminophen is no more than four grams daily.

66. Respondent committed gross negligence when he prescribed medications in amounts containing more than four grams per day of acetaminophen. As will be seen in the Findings regarding the individual patients, Respondent's documentation of the care of the patients for whom he prescribed such dosages does not support his opinion that they were not in danger of liver damage. He relied entirely on their self-report to conclude that auto-protection applied. He did not account for their weight (although it was not established that it was relevant) and almost never ordered testing. His prescribing put his patients at risk, without valid reason, because the amounts he prescribed were far greater than necessary. Respondent's assertions that he monitored and knew his patients so well that it was safe for him to prescribe

in excess of the amount established as the standard of care for the general public were not credible.

Expert opinion evidence: prescribing Phenergan with codeine

67. The second topic Dr. Benowitz discussed involved the issue of prescribing Phenergan with codeine cough syrup (PCCS) as a sleep aid to chronic pain patients. Dr. Benowitz described the medication; he did not opine on the suitability of its use by Respondent. It contains promethazine, which is an antihistamine that has different uses. It has anti-nausea, anti-vomiting, and sedating effects. It is used for allergies and colds, and in the past, was used for sleep, but is essentially an antihistamine. Codeine is an opiate, and works as a cough suppressant and as a pain-reliever. It can also cause nausea. The combination of the two drugs can be very effective, as well as convenient. But if given with other drugs that also have sedative effects, the patient must be watched for oversedation.

68. Respondent prescribed PCCS for all eleven patients in this matter as a sleep aid, and often to be taken as needed as a general aid to relaxation. Respondent testified as regards one patient, that he prescribed PCCS "to make his life worth living." He also contradicted his own representation that it was a good choice as a sleep aid. Respondent appeared to agree that the quality of the sleep produced was light, in that he testified that it caused his patients to experience unusual dreams. In sum, his explanations for the prescriptions were confusing and illogical.

69. Dr. Miller and Dr. McCarberg both opined that Respondent's prescriptions of PCCS for his pain patients were extreme departures from the standard of care. It has a negative effect on REM sleep. Although Dr. Wilcosky appeared to give Respondent wide leeway in his decisions regarding medications, he acknowledged that he knew of no other physician who routinely prescribed PCCS for sleep.

- *conclusions*

70. PCCS is essentially a cough medicine, but prescribing medications for off-label uses can be within the standard of care. In this instance, however, it is determined that Respondent's prescribing of PCCS was excessive and improper and violated the standard of care. Respondent's documentation as regards the eleven patients herein rarely reflects a complaint about sleep. It was established that the sleep produced with the assistance of PCCS was not the deep sleep needed for good health. Further, Respondent prescribed amounts of PCCS far in excess of what a patient would need in a given month, and always in addition to large amounts of other sedating medications.

Findings on allegations concerning particular patients

PATIENT IG

71. Patient IG was a 60-year old female, and Respondent treated her from September 11, 2008, until 2010. His initial notes reflect that she had a history of alcohol abuse, anxiety and depression, had not worked in ten years, and was receiving Social Security Disability Income (SSDI). IG complained of low back pain radiating down both legs, as well as pain in her shoulders, knees, neck, wrist, feet, head and fingers, which she described as 10 out of 10 on the pain scale. Respondent made an initial diagnosis of lumbar radiculopathy, cervical spondylosis, foot deformity bilaterally, osteoarthritis of the knee, a right wrist problem, chronic pain syndrome, chronic bronchitis, post-peptic ulcer, and frontal headaches. IG had been prescribed 30 mg temazepam for sleep and #100 hydrocodone 7.5 mg tablets per month by another physician.

72. Respondent did not perform a physical examination. He requested x-rays, but did not follow up when they were not provided. He requested records from Brookside Hospital, and they were added to IG's chart when received on a later date. Nonetheless, on the first visit, Respondent prescribed the following medications: #120 OxyContin 80 mg. tablets (the highest available dose); #240 Norco 10/325 mg tablets (8 per day); 32 oz PCCS; #180 Soma 350 mg tablets (6 per day); and #120 Valium 10 mg. tablets.

73. The records from Brookside revealed that IG had been dismissed by her previous physician for not following through with ordered laboratory studies or therapy. In May 2008, IG had been diagnosed with peptic ulcer disease, alcoholism, chronic low back pain, and headaches possibly secondary to Vicodin use. On May 30, 2008, she tested positive for Dilaudid and oxazepam, despite not having been issued prescriptions for those medications. And there is a chart note that indicates IG was seen at Brookside on September 26, 2008, for "general pain," but no indication that she informed the physician who saw her that she was by then being treated by Respondent for pain.

74. A CURES patient activity report for IG from July 1, 2007, through December 11, 2008, shows that IG received prescriptions, mainly for Vicodin, from eight different doctors, and that she used two different pharmacies during that time period.

75. Following the initial visit in September 2008, Respondent continued to issue primarily the same prescriptions to IG. They were issued following IG's reports of feeling better and that she was doing well. On both February 6 and May 1, 2009, Respondent issued sequential prescriptions for the following three months. Respondent never received x-rays or other tests results to confirm his initial impressions or to assist his treatment of IG.

76. There is no written indication that Respondent obtained informed consent for his treatment of IG and there was no written treatment plan.

77. A chart note on August 12, 2009, states that IG had missed an appointment and had run out of medications. She had been in Michigan and had two deaths in her family. She also told Respondent that she had last taken medication three weeks prior, and that her pain level was then 7/10. Respondent issued sequential prescription for three months of: #120 OxyContin 80 mg, #180 Soma 350 mg, #240 Norco 10/325, #120 Valium 10 mg and 32 oz PCCS.

78. IG's last visit to Respondent was on November 4, 2009. His notes state that she had slow speech and difficulty relating details, was under a great deal of stress, that five family members had died, that her daughter was ill, and that she felt "like checking into a mental hospital." She reported pain levels of 7/10 in her back, shoulders and legs, and that she was suffering from swollen feet, headaches, and lack of sleep.

Respondent did not perform a physical or mental examination. He issued sequential prescriptions for the same medications, and added Elavil, for pain.

79. On January 22, 2010, Respondent received a telephone call informing him that IG had been found dead on the kitchen floor of her home. He was asked to complete the death certificate and identified the cause of death as cerebrovascular accident. Respondent testified that he had no basis for concluding that this was the cause of death, and there was no indication in IG's medical records that this would have been an accurate diagnosis. He did not recommend a post-mortem examination, which was a simple departure from the standard of care.

80. Given IG's history of substance abuse and the lack of objective findings that would have supported her reports of pain in multiple areas, IG was not an appropriate candidate for sequential prescriptions. She clearly required closer monitoring, and yet Respondent never obtained a drug screening, a CURES patient activity report, or a pharmacy prescribing profile.

81. Respondent testified that he examined IG, and that he based his treatment of her on his clinical judgment. He trusted that what she told him about her pain was true, and designed her medication regimen accordingly. It appears he thought that her reference to checking in to a mental hospital was an offhand remark. Respondent did not feel the need for any testing, although he did order x-rays at first. It appears that he felt under some pressure to give a cause of death, which he felt in any event was either a stroke or heart failure. Respondent made contradictory statements, however, as to whether IG suffered from hypertension.

82. The following treatment of IG by Respondent constituted gross negligence:

a. Diagnosing cervical spondylosis without objective findings to support the diagnosis.

b. Failing to adequately assess IG's psychological functioning.

c. Diagnosing lumbar radiculopathy without a physical examination and findings to support the diagnosis.

d. Prescribing excessive amounts of dangerous drugs before first conducting an appropriate medical examination and without medical indication.

e. Prescribing excessive starting doses of 320 mg daily of OxyContin and eight tablets daily of Norco.

f. Failing to obtain and document informed consent from IG for the course of treatment.

g. Failing to conduct meaningful periodic reviews of IG's progress, including by obtaining random drug screens and/or a CURES patient activity report.

h. Failing to adequately assess IG's psychological functioning on August 12 and November 4, 2009.

83. The following treatment of IG by Respondent constituted negligence:

a. Failing to recommend a post-mortem evaluation to determine a cause of death.

b. Failing to document a treatment plan.

84. Respondent was incompetent in his care of IG, in that he demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology. The incompetent care included, but was not limited to: failing to start and titrate opiates gradually; failing to recognize the addictive effects of sedatives; failing to recognize that combining sedatives with agents that suppress respiration can result in harm; failing to recognize that prescribing high doses of sedatives along with other medications can produce harmful drug interactions; and prescribing PCCS for sleep.

85. Complainant alleged that Respondent was grossly negligent by prescribing PCCS to IG, given that she had chronic bronchitis. Respondent mentioned chronic bronchitis, but that diagnosis was not substantiated. Therefore, the allegation was not proven.

86. Complainant alleged that Respondent was negligent by failing to consider referring IG to another pain specialist and/or failing to consult with another pain specialist about the care of IG. This allegation was not proven.

PATIENT KM

87. Patient KM was a 38-year old male paraplegic confined to a wheelchair when Respondent first saw him at APMR on December 1, 2006. KM was paralyzed in the thoracic spine, from the level of approximately the diaphragm downwards. KM described his chief complaint as neck pain, consisting of stabbing, burning, and throbbing. Respondent examined

KM's cervical range of motion. KM told Respondent that he had a primary care physician, who had been prescribing #60 OxyContin 80 mg monthly, and diazepam.

KM reported to Respondent that his paralysis followed a gunshot wound. He had been arrested the previous year for being drunk in public and had been convicted and placed on probation for cocaine abuse. Also, KM stated that he obtained Norco from friends and occasionally used marijuana.

88. The standard of care in a chronic pain setting is to go slow and add one agent at a time. This enables the physician to determine which medications are effective and the lowest possible effective dose. Dr. Miller advised that for KM, Respondent should have kept the OxyContin constant and added Cymbalta. Instead, at the initial visit, Respondent prescribed #180 OxyContin 80 mg; Cymbalta 30 mg, twice daily; #180 Diazepam; #120 Norco; and issued a marijuana recommendation. On January 22, 2007, Respondent called in refills for #120 Norco 10/325 and #60 Soma 350 mg.

89. At the initial visit, Respondent tripled the previously prescribed dose of OxyContin issued by KM's primary care physician. This was an irrational and dangerous titration of OxyContin.

90. On January 26, 2007, KM reported to Respondent that his medications had been stolen. Respondent prescribed #240 OxyContin 80 mg, #180 Norco 10/325, #180 Diazepam 10 mg, #180 Ativan 2 mg, and #30 Lidoderm patches.

91. On August 24, 2007, KM came to Respondent's new office. Respondent saw KM while KM remained sitting in a car outside, and without any physical examination. Respondent refilled his medications and asked him to return in four weeks. On September 7, 2007, however, KM reported that he had lost his medications when he was involved in a car accident. Although Respondent noted in the chart that he suspected KM to be living in an environment of drug dealers, he issued an early refill of #120 OxyContin 80 mg.

92. Throughout his treatment of KM, and despite obvious signs that were noted by Respondent, Respondent continued to prescribe and increase the dosages of dangerous drugs and controlled substances. Respondent was aware that many of the medications he prescribes have significant monetary value and are sold "on the street." Nevertheless, Respondent issued early refills or replacements of medications that KM reported lost or stolen.

93. Respondent increased the dosage amounts in the prescriptions for KM without documenting any medical indication for doing so. For example, on October 12, 2007, Respondent issued prescriptions for #240 OxyContin 80 mg, and #180 Valium 10 mg, yet also increased Norco 10/325 from #240 to #300, and added #120 Dilaudid 8 mg, and #30 Ambien 10mg and 32 oz PCCS.

94. On December 7, 2007, Respondent noted that KM had been hospitalized for three weeks for an elbow infection. Respondent did not obtain any medical records as regards

this incident. He increased the amounts of OxyContin 80 mg to #300, and of Norco 10/325 to #360. He also prescribed Valium, Dilaudid, Restoril, Fentora, and PCCS.

95. On December 14, 2007, KM signed a statement that he had a lock box for his medications and would not lose them again. KM, however, reported losing prescriptions on multiple occasions following signing the statement. Respondent routinely issued replacements.

96. On February 1, 2008, Respondent increased KM's medications to the extent that the daily dosages contained 4.3 grams of acetaminophen. Respondent did not document that he obtained informed consent or warned KM about the risks of taking more than 4 grams a day of acetaminophen.

97. On March 7, 2008, just two weeks after seeing Respondent and being issued prescriptions for #300 OxyContin, #400 Norco, and #200 Soma, KM told Respondent he had lost the prescriptions. Respondent issued a prescription for #400 Norco, #200 Soma and 48 oz PCCS. A CURES report reveals that all of the prescriptions were filled.

98. On March 14, 2008, Respondent issued a prescription to KM for #360 OxyContin, #400 Norco and 32 oz PCCS. On March 27, 2008, he prescribed #360 OxyContin, #400 Norco, and 32 oz PCCS. On April 11, 2008, Respondent did not see KM, but gave KM's niece prescriptions for KM for #400 Norco, #200 Soma and 32 oz PCCS. In sum, in a two-month period, KM received prescriptions totaling #1020 OxyContin 80 mg.; #2000 Norco 10/325 mg; #600 Soma and one and one-half gallons (192 oz) of PCCS.

99. Despite the quantities of medications prescribed and KM's history of lost and stolen medications and prescriptions, on May 9, 2008, Respondent began issuing sequential prescriptions. Respondent issued three months' of sequential prescriptions for OxyContin. On August 1, 2008, Respondent again issued sequential prescriptions for OxyContin.

100. On September 5, 2008, Respondent noted that KM's sister threw out his medications when she cleaned the house. Respondent refilled #360 OxyContin 80 mg.

101. On September 26, 2008, Respondent introduced methadone to KM's medication regimen. The starting dose was 80 mg per day, far in excess of the typical starting dose of between 22.5 mg and 45 mg, taken in three doses over the course of one day. There was no medical indication for the addition of methadone.

On the same day, Respondent issued two prescriptions for OxyContin, for a total of #720 OxyContin 80 mg tablets. KM filled one of them the same day and the other one the following day.

102. On December 10, 2008, Respondent noted that KM was hospitalized for two weeks for presumptive gastroenteritis and was treated with pain medications while hospitalized. Nonetheless, Respondent refilled KM's prescriptions as follows: #360 OxyContin, #400 Norco 10/325, #240 methadone 10 mg, and 120 oz PCCS.

103. Beginning on February 27, 2009, Respondent noted calls from pharmacists at approximately five different pharmacies regarding the prescriptions he was writing for KM. The issues of concern included paying cash, the use of multiple pharmacies, early refill requests, other persons attempting to fill his prescriptions, and large amounts of OxyContin.

104. On November 27, 2009, Respondent noted that he had been informed that KM had suffered a stroke. On December 9, 2009, without having seen KM, Respondent issued prescriptions in the same quantities he had prescribed previously: #360 OxyContin (sequentially for three months), #300 methadone, #90 Xanax, #250 Norco, #300 sodium ducosate, and PCCS.

105. On February 12, 2010, KM's mother came to Respondent's office and picked up early refills of Xanax, Norco and PCCS. Respondent noted that KM had lost his medications, and was hospitalized with a respiratory problem.

106. On March 3, 2010, Respondent saw KM for the first time following the stroke. KM, a paraplegic, at that point had a recent history of stroke that affected his entire right side and respiratory problems that led to hospitalization. Respondent did not document that he conducted a physical examination of KM. He prescribed three months' worth of medications, including #300 methadone, #120 Xanax 2 mg, #300 Norco and 80 oz PCCS. He also gave him sequential prescriptions for #360 OxyContin, illegally postdated on March 31 and April 28, 2010.

107. On March 20, 2010, KM died. The coroner identified the cause of death as polysubstance abuse with toxic levels of Xanax and methadone. There was no OxyContin in his system.

108. On April 13, 2010, Respondent's prescription for KM for OxyContin dated March 31, 2010, was presented at Bacon East Pharmacy in Concord and paid for in cash ($4,681) by a man claiming it was for his terminally ill uncle. Martin Gaballa, the pharmacist, called Respondent's office to obtain some information on the same day. The pharmacy served hospice patients, and the amount did not seem out of the ordinary, but Gaballa was concerned that he did not recognize the patient's name and for other reasons. There was no answer. The following day he was able to leave a message and Respondent returned the call, telling Gaballa that KM was deceased and that he had been terminally ill. Respondent called Gaballa again later with the name of the person he had contacted in the district attorney's office to report the incident.

109. Respondent described KM as a difficult patient to manage and stated that he did entertain suspicions that drugs were being diverted. But he also stated that it would have been "nice" if he was aware of the diversion. Regardless, Respondent never obtained CURES reports concerning KM or required that he submit to drug screening tests. When presented with CURES reports concerning KM at hearing, Respondent did not appear to know how they were

set up or how to read them. When asked if he made any changes to his prescription practices after his experiences with KM, Respondent answered "no, because my method was better."

110. The following treatment of KM by Respondent constituted gross negligence:

a. Failing to perform an adequate history and physical examination.

b. Failing to adequately assess KM's psychological functioning.

c. Increasing the doses of medications at various times during treatment without documented medical indication, for example, the tripling of a previous prescription for OxyContin by another physician from two to six pills per day at the initial visit.

d. Prescribing more than 80 mg daily of methadone, which was an excessive amount.

e. Failing to obtain and document informed consent from KM for the course of treatment.

f. Failing to conduct meaningful periodic reviews of KM's progress, including by obtaining random drug screens and/or a CURES patient activity report.

g. Failing to consult with another pain specialist concerning the care of KM.

111. The following treatment of KM by Respondent constituted negligence:

a. Failing to document a treatment plan.

112. Respondent was incompetent in his care of KM, in that he demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology. The incompetent care included, but was not limited to: failing to recognize that he was prescribing toxic and potentially fatal doses of controlled substances; routinely issuing early refills of narcotic medications; failing to recognize the probability that KM had substance abuse problems; failing to obtain objective data to substantiate the prescribing of large quantities of controlled substances; and prescribing PCCS for sleep.

113. Complainant alleged that Respondent "failed to recognize that KM likely had a psychiatric disorder, which meant that he should not be treated by a solo practitioner and probably should not be treated with controlled substances." Dr. Miller opined at length about the anti-social behaviors exhibited by KM, and Respondent's apparent failure to recognize the threat that he presented to himself and to the community, given the likelihood that he was not taking all of the medications prescribed and that they were ending up in the hands of others. The evidence supported these opinions, but not that KM suffered from a specific psychiatric disorder, as Dr. Miller was not qualified as an expert in psychiatric disorders. KM clearly led a troubled life, but there is insufficient information in the record to conclude that he suffered from

a particular psychiatric disorder and it was not established that Respondent was negligent in failing to diagnose him with one. Therefore, these allegations were not proven.

114. Complainant alleged that Respondent's issuance of a postdated prescription on March 31, 2010, was a dishonest or corrupt act. This allegation was not proven. Respondent's issuance of the postdated prescription violated the law regarding the issuance of prescriptions, but it was not a dishonest or corrupt act.

PATIENT JD

115. Patient JD was a 35-year-old female, and Respondent treated her from October 22, 2008, until January 14, 2009 – a total of three months. His initial notes reflect that she had a history of alcohol abuse, and had run away from home at age 15. She had three children who had been removed from her care. JD complained of pain in her knee, thigh and flank, and of migraine headaches. She described her pain level as 10/10, and at best as 3/10. She told Respondent that she had been receiving #20 to #30 Vicodin ES from hospital emergency room visits, #24 Norco, Synthroid, sodium citrate, Prilosec and magnesium. Respondent made an initial diagnosis of musculoskeletal pain secondary to renal tubular acidosis (RTA), which is a metabolic kidney disease. RTA can be treated with sodium citrate, and once resolved, is not chronically painful. Respondent did not attempt to obtain or obtain any medical records concerning JD prior to treating her.

116. Respondent did not undertake to treat JD for RTA. He instead prescribed #60 OxyContin 80 mg; #240 Norco 10/325 mg; #180 Soma 350 mg; #120 Valium 10 mg; #90 Phenergan 25 mg; and 16 oz. of PCCS. This prescription regimen was without medical indication and the starting dose of eight pills per day of Norco and six pills per day of OxyContin was excessive.

117. On November 4, 2010, Respondent saw JD and prescribed a variety of medications that contained significant amounts of acetaminophen. Liver failure can result from large amounts of acetaminophen, and the standard of care requires a warning about the potential for harm. In addition, there is no indication in the medical record that Respondent warned JD about the hazards of taking an over-the-counter medication that contained acetaminophen at the same time as her prescribed medications.

118. On November 8, 2008, Respondent noted that JD had been hospitalized and lost her Norco. He prescribed #120 Norco 10/325 with three refills.

119. On November 19, 2008, Respondent noted that JD reported her worst pain as 9/10, but there is no indication of the location or type of pain. She reported that she was unable to get OxyContin, that she could tolerate Dilaudid but not morphine, and that she was able to work part-time because of the Norco. Respondent then prescribed #300 Norco 10/325, #200 Soma 350 mg, #120 Valium 10 mg, 16 oz PCCS, #90 Phenergan 25 mg tablets, #10 fentanyl 100 mc patches, #120 methadone 10 mg tablets, and #30 Ativan 1 mg. There was no medical indication for adding fentanyl and methadone.

120. On December 4, 2008, Respondent noted that JD called and said that she lost half of her Norco. He called in a prescription for an additional #100 Norco.

121. On December 17, 2008, Respondent noted that JD said the fentanyl patches were helping a lot and that her worst pain was 2 or 3/10. Respondent discontinued methadone, but continued to prescribe #10 fentanyl mc patches along with #300 Norco, #200 Soma, #120 Valium, #30 Ativan, #90 Phenergan 25 mg, and 16 oz PCCS.

122. On January 14, 2009, Respondent issued two separate prescriptions to JD. One was for Norco and Vicodin ES, and one was for fentanyl, Soma, Valium, Ativan, and PCCS. She was to return in four weeks.

123. JD died on January 23, 2009. The autopsy report identified the cause of death as fentanyl toxicity. The level of fentanyl in her system was three times higher than the therapeutic dose. In addition, her acetaminophen level was very high. The toxic level is from 160 to 390 micrograms, and JD's level was 140 micrograms, which is seven times the top therapeutic range. The autopsy revealed that JD suffered from liver damage; her liver was not able to adequately metabolize the amount of fentanyl in her system.

124. Because JD reported that she had been in pain since 1991, and there was ample time for it to develop, Respondent concluded that she had chronic pain syndrome. Respondent did not consider a lower dose of any of the medications he prescribed for JD because he believed her representation that such had already been tried and had been unsuccessful. He acknowledged that the fentanyl dose was the largest available, but opined that it was necessary to treat the chronic pain syndrome. Respondent was not concerned that his regimen of medications would be overly sedating and would place JD at risk. He did not feel it necessary to reduce the other sedating medications when he prescribed the fentanyl. Respondent does not feel any responsibility for JD's death.

125. The following treatment of JD by Respondent constituted gross negligence:

a. Failing to obtain an adequate history or to assess JD's psychological functioning.

b. Failing to conduct an adequate physical examination.

c. Prescribing excessive amounts of dangerous drugs without a substantiated medical diagnosis or medical indication.

d. Prescribing excessive starting doses of OxyContin and Norco.

e. Failing to obtain and document informed consent from JD for the course of treatment.

f. Failing to conduct meaningful periodic reviews of JD's progress, including by obtaining random drug screens and/or a CURES patient activity report.

126. The following treatment of JD by Respondent constituted negligence:

a. Failing to document a treatment plan.

127. Respondent was incompetent in his care of JD, in that he demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology. The incompetent care included but was not limited to: failing to recognize that he prescribed an inherently dangerous and potentially fatal combination of sedatives; failing to recognize that sedating agents can be addictive; failing to recognize that combining sedatives with agents that suppress respiration can result in harm; and prescribing PCCS for sleep.

128. Complainant alleged that Respondent diagnosed musculoskeletal pain secondary to RTA which is not supported by physical examination and objective findings, and then prescribed narcotics to treat the RTA. Respondent did make the alleged diagnosis, and he prescribed narcotics; but it was not proven that he prescribed the narcotics to treat the RTA. Therefore, this allegation was not proven.

129. Complainant alleged that Respondent was negligent by failing to consider referring JD to another pain specialist and/or failing to consult with another pain specialist about the care of JD. This allegation was not proven.

130. Complainant alleged that Respondent "failed to recognize that the patient may have had a personality disorder that would mean that she should not be treated with controlled substances by a sole practitioner." This allegation was not proven.

PATIENT WR

131. In July 2008, when she was first seen by Respondent, WR was 58 years of age. WR suffers from the after-effects of a gunshot wound to her head, including some cognitive difficulties. She has had extensive therapy and can write, but not read. WR testified at hearing in support of Respondent. Although her speech was somewhat slow, she often appeared to understand the questions asked and answered intelligibly. She occasionally, however, appeared confused, and contradicted herself.

WR testified that that she completed a Patient Testimonial form during each office visit, but there are only two completed forms in her records, even though she saw Respondent eleven times between July 2008 and July 2009. She also testified that Respondent required her to submit to blood and urine tests every two months, "or he wouldn't see me," but the record contains only one blood test report. In addition, she testified that Respondent always took her blood pressure, listened to her heart, and took her pulse. Respondent's testimony contradicts these assertions. Overall, it appeared that WR said what she felt was necessary to support Respondent; she is clearly grateful for Respondent's care and trusts him. In closing, WR stated

that she had knee replacement surgery, and that she is "walking better as a result of [Respondent's] care."

132. Respondent's records reveal that during her first visit with Respondent, WR complained about pain in her right knee and low back. WR's primary care physician had previously diagnosed her with arthritis in her back and with anxiety, and she was taking Valium and Soma. She reported constant pain in the right knee at levels between 2 and 10/10. Respondent diagnosed osteoarthritis of the knee with lumbar spondylosis. He prescribed 32 oz PCCS, #240 Norco 10/325, #120 Valium 10 mg, and #120 Soma 350 mg. There was no medical indication for the prescriptions for Valium, Soma, and the PCCS. The use of Norco may have been warranted.

133. Records Respondent subsequently received after the first visit showed that WR reported vague pain complaints in May 2005 and was diagnosed with significant anxiety in September 2007. An MRI taken July 14, 2008, showed a torn meniscus and osteoarthritis in her right knee.

134. On August 29, 2008, Respondent refilled WR's prescriptions, including increasing the Valium and Soma, and adding #60 OxyContin, without medical indication.

135. On September 24, 2008, WR underwent arthroscopic surgery to her right knee. Respondent saw her two days later. He prescribed #120 OxyContin 80 mg, 240 Norco 10/325, #140 Valium 10 mg, #150 Soma 350 mg, 32 oz PCCS, and introduced #100 Elavil 25 mg. He did so without an indication that he had consulted with her surgeon. Respondent provided post-operative care to WR without consulting or collaborating with her surgeon or other treating physicians.

136. The standard of care for titration of opioids is no more than 25 percent at one time. Respondent doubled WR's OxyContin prescription on September 24, 2008, violating the standard. He continued to prescribe for WR, although his records are unclear as to whether he saw her in person.

137. On January 16, 2009, Respondent noted that WR was in the hospital due to a "breakdown." On February 13, 2009, he noted that she was unable to relate history day-by-day and had been assigned a caretaker by the County. Respondent refilled WR's prescriptions, including giving three additional refills. He provided sequential prescriptions for OxyContin, and later added Vicodin ES.

138. On July 31, 2009, Respondent noted that WR was to have arthroscopic surgery on August 10, 2009. He refilled WR's medications as follows: #240 Norco, #140 Valium, #120 OxyContin, #90 Elavil, and 32 oz PCCS.

139. During the one year of treatment of WR documented in the record, no informed consent was documented, no drug screenings were ordered, and no CURES reports were obtained.

140. It is standard of care to prescribe anti-inflammatory medications (NSAID's) for arthritis pain. Respondent testified that he did not prescribe NSAID's to WR, or to any of his patients, because NSAID's "are hard on the kidneys."

141. When asked how he arrived at the dosage amounts for the prescribed medications, Respondent replied that he evaluated the pain level, the history of medications, WR's history and what she might need. This assertion was belied by the fact that Respondent prescribed large doses of medications known to negatively impact cognition to a patient with cognitive difficulties. He prescribed ever-increasing amounts of opioids in a pattern similar to all of the patients he diagnosed with chronic pain syndrome, seemingly without regard to WR's unique presentation.

142. The following treatment of WR by Respondent constituted extreme departures from the standard of care and gross negligence:

a. Failing to perform an adequate history and physical examination.

b. Failing to adequately assess WR's psychological functioning.

c. Prescribing excessive amounts of Soma, Valium, and PCCS without a substantiated diagnosis or medical indication.

d. Prescribing excessive doses of OxyContin.

e. Failing to obtain and document informed consent from WR for the course of treatment.

f. Failing to conduct meaningful periodic reviews of WR's progress, including by obtaining random drug screens and/or a CURES patient activity report.

143. The following treatment of WR by Respondent constituted negligence:

a. Failing to document a treatment plan.

b. Failing to prescribe NSAID's following his diagnosis of osteoarthritis of the knees.

144. Respondent was incompetent in his care of WR, in that he demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology. The incompetent care included, but was not limited to, prescribing PCCS for sleep.

145. Complainant alleged that Respondent failed to consider referring WR to another pain specialist and/or failed to consult with another pain specialist concerning the care of WR. It was not established that this was required by the standard of care.

PATIENT JS

146. On June 2, 2006, JS saw Respondent at APMR. She complained that she had low back pain radiating down her right calf. The pain level was from 8 to 10/10. Respondent noted that she was a "private duty nurse (CNA)," and had not worked for the past year. JS was injured in 2004 in Seattle when moving a patient. An MRI was obtained, but she did not bring the results with her. Respondent also noted that JS had worked as a drug and alcohol recovery counselor. JS was married to RB, who was also Respondent's patient. She denied any drug abuse history and admitted to drinking alcohol twice a year.

Respondent diagnosed cervical and lumbar radiculopathy and listed other conditions, including trigger finger, migraine headaches, chronic pain syndrome with depression, and asthma. He did not conduct a physical examination that supported the diagnosis of cervical and lumbar radiculopathy. JS reported to Respondent that she "shared" medications with her grandmother, who was suffering from colon cancer. He prescribed #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma 350 mg, #120 Xanax 2 mg, and 16 oz PCCS.

147. On July 7, 2006, JS reported pain levels from 7 to 10/10, but also that the medications Respondent prescribed were the best she had ever had. She said that she had mailed the MRI results, but they were not received, and she stated she would bring them next time. (JS never provided any MRI results to Respondent.) Respondent prescribed #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma 350 mg, #120 Xanax 2 mg, Lidoderm patches and 8 oz PCCS. There are some handwritten calculations on the note for that date that appear to conclude that JS's daily doses of Vicodin and Tylenol together include 7.8 grams of acetaminophen. (The amount is actually 6.3 grams.)

148. On August 6, 2006, there is a note that Respondent ordered a series of lab tests that included a test for liver function. But there is no indication that such test was performed or any results received.

149. On December 22, 2006, Respondent noted that JS reported radicular pain in her right arm and right lower extremity, migraine headaches, and pain in the neck, low back, elbows and hips. No physical examination is documented. Respondent increased the PCCS to 32 oz, and prescribed the same amounts of Vicodin, Tylenol, Soma and Xanax. He added Imitrex and lactulose.

150. On August 17, 2007, JS reported that the medications were working well and that she was functioning satisfactorily. Respondent documented lumbar radiculopathy of the right lower extremity, bilateral knee osteoarthritis, and stable program in management. He asked her to return in twelve weeks and prescribed 32 oz PCCS times two with two refills, #240 Vicodin ES with two refills, #180 Tylenol No. 4 with two refills, #180 Soma with three refills and #120 Xanax 2 mg with three refills.

But Respondent saw JS again in just four weeks: on September 14, 2007. And he prescribed 32 oz PCCS times two with two refills, #240 Vicodin ES with two refills, #180 Tylenol No. 4 with two refills, #180 Soma with two refills and #120 Xanax 2 mg. with two refills.

151. On March 28, 2008, Respondent noted that JS "wants more pain relief." Respondent introduced OxyContin at that time, prescribing #120. He did not document any physical examination or objective findings. He also prescribed #180 Tylenol No. 4, #240 Vicodin ES and #90 Flexeril.

152. On December 20, 2008, Respondent issued three months' worth of prescriptions of #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma, #120 Xanax and 32 oz PCCS, as well as sequential prescriptions of #120 OxyContin dated January 7 and February 4, 2009. There was no note of JS losing the three months' worth of prescriptions issued on September 26, 2008, which was the prior visit. And yet, on January 2, 2009, JS told Respondent that she lost her prescriptions dated September 26, 2008. Respondent then, inexplicably, issued three months' more of prescriptions.

153. When asked about the incidents of replacing the prescriptions described above, Respondent testified that he could not explain them and that they were mistakes. When asked if he was concerned that JS might have been diverting drugs, Respondent replied that he took care of other family members; that JS's mother would not allow her to do that; and that "they would be in jeopardy of losing me so would not do anything like that."

154. On April 25, 2008, JS reported to Respondent that she had slipped and fallen nine days before in Walmart. Respondent then noted that she had fractured her right patella and was walking with a limp. JS reported that she would see an orthopedist in a few days, and that she had received a brace in the emergency room. It was not clear whether Respondent was himself diagnosing a fracture, or noting what JS had said to him. Inexplicably, it appears that JS did not report an increase in pain level at that time.

155. On January 27, 2010, Respondent was informed that JS had been hospitalized for four days in Kansas for a respiratory illness and was placed on Prednisone and on oxygen at home. He continued to prescribe controlled substances, and increased the OxyContin to #180 without seeing JS or obtaining her treatment records.

156. Respondent continued with a similar prescribing practice for JS. His last note in the record was February 24, 2010, and states that JS had pulmonary fibrosis and was on oxygen at home. Respondent did not conduct a physical examination or consult JS's other physicians. He issued prescriptions for #180 OxyContin, #180 Tylenol No. 4, #240 Vicodin ES, #180 Soma, #90 Xanax, and 48 oz PCCS.

157. Respondent's prescribing for JS routinely included large doses of acetaminophen. The records do not indicate that he obtained informed consent from JS in any

respect or that he warned her about the dangers of liver damage from large doses of acetaminophen.

158. The following treatment of JS by Respondent constituted gross negligence:

a. Failing to perform an adequate history and physical examination.

b. Failing to adequately assess JS's psychological functioning.

c. Prescribing excessive amounts of Soma, Xanax and PCCS without a substantiated diagnosis or medical indication.

d. Failing to warn JS of the hazards of excessive amounts of acetaminophen, including the amount that was contained in her prescription medications, and of the risk of adding to those amounts by taking over-the-counter drugs containing acetaminophen.

e. Failing to obtain and document informed consent from JS for the course of treatment.

f. Failing to conduct meaningful periodic reviews of JS's progress, including by obtaining random drug screens and/or a CURES patient activity report.

g. Diagnosing cervical and lumbar radiculopathy without a documented physical examination and objective findings to support the diagnosis.

159. The following treatment of JS by Respondent constituted negligence:

a. Failing to document a treatment plan.

160. Respondent was incompetent in his care of JS, in that he demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology. The incompetent care included, but was not limited to: consistently prescribing more than four grams of acetaminophen daily for a period of time and prescribing PCCS for sleep.

161. Complainant alleged that Respondent was guilty of unprofessional conduct for failing to refer JS to an orthopedic specialist. It was not established that such referral was required by the standard of care; therefore, this allegation was not proven.

162. Complainant alleged that Respondent diagnosed a healing fracture of the right patella without a documented physical examination and objective findings to support that diagnosis. This allegation was not proven.

PATIENT RB

163. On August 24, 2007, Respondent saw RB, a male age 59, in his new office. His chief complaint was low back pain radiating down both of his legs, which developed after carrying a sofa. RB said he had used over-the-counter medications and denied having a primary care physician. He said he did not get medications from other doctors, but that he occasionally got medications from his friends. RB reported that Vicodin ES, Soma, Xanax and promethazine with codeine were helpful to him, but that Vicodin and Soma were "not satisfying." Respondent's impression was lumbar degenerative disc disease, and he ordered lumbar spine x-rays.

Respondent did not perform a complete physical examination as regards RB's back pain complaint. He prescribed #140 Vicodin ES, #60 Soma 350 mg, #60 Xanax 2 mg, and 16 oz PCCS. There was no medical indication to prescribe Xanax or PCCS.

164. During a visit on December 7, 2007, RB told Respondent that he had lied about his identity, and that this had led to the refusal of a prior physician to treat him. At hearing, RB testified that he initially lied to Respondent in 2007 and did not tell him that he had seen him previously at APMR or that he was patient JS's husband. This was because someone had taken his prescription and tried to use it, including forging his name. RB's testimony was difficult to follow in some respects, possibly due to the medications he testified that he had consumed that day.

It is clear, however, that Respondent was aware at the December 7 visit that RB had lied to him in the past, and to another physician. Nonetheless, Respondent issued three months' worth of medications. He increased Vicodin ES from #140 to #240 (eight daily) in addition to prescribing #120 Tylenol No. 4, #120 Valium 10 mg, #120 Soma 350 mg, and 32 oz PCCS. The dosage increases were dangerous and also resulted in a toxic level of acetaminophen.

165. On March 7, 2008, RB reported that he had significant pain. Respondent noted spondylolisthesis at L5-S1. This is a normal finding for a patient of RB's age, and is not normally a painful condition. He added #120 OxyContin 80 mg, #120 Vicodin ES, #120 Soma 350 mg, 32 oz PCCS, and #30 Nexium 40 mg. This regimen contained a toxic dose level of acetaminophen and a dangerous increase in dosage of OxyContin.

166. On April 4, 2008, Respondent noted that RB was taking the OxyContin "haphazardly if I can believe his story." He instructed RB to take two OxyContin every twelve hours. Respondent testified that he also instructed RB to take the OxyContin as instructed, or "not bother coming to me." He reasoned that because he was also treating two of RB's wife's relatives, including his wife's mother, that he had "a little control" through the family connection, and it might be safe to treat RB and JS. Respondent asserted that JS was doing very well at that time, and that he was "working on" RB. Respondent also related that if his patients still reported pain a pain level of 9/10, this meant that they were not taking the medication he prescribed.

167. On the June 6, 2008, visit, RB reported pain levels of 8 or 9/10, and also that he had experienced an absence of pain. RB informed Respondent that he was scheduled for knee surgery. Respondent testified that this was the first he had heard about a knee problem. Respondent issued sequential prescriptions, reasoning that because of the surgery scheduled for June 27, RB would not be able to come in for appointments.

168. On January 16, 2009, Respondent noted that RB's pain level was 6/10 at best and 8/10 at worst. He was taking OxyContin as prescribed, but RB told Respondent that he "would like Norco instead of Vicodin ES." Respondent issued sequential prescriptions, without noting the names or dosages in his records.

169. On April 10, 2009, Respondent noted that a fentanyl patch was causing "nausea, dizziness, ill feeling." There is not a note prior to this concerning a fentanyl prescription, but a prescription for #10 fentanyl patches was issued April 3. No documented physical examination or medical indication exists for this prescription. Respondent testified that RB told him he wanted to try a long-acting morphine medication, MSCR. There is also a note that indicated difficulty filling an OxyContin prescription.

170. An April 24, 2009, note states "MSCR causing nausea according to his call to office. 3pm I tried to call [RB]. No ans. Dc morphine! Pt got the previous Rx for OxyContin filled."

171. On September 25, 2009, RB reported pain levels of 7 at worst and 0 at best. It was in his low back, going down his right leg past his knee. Respondent added methadone, and issued sequential prescriptions, including increases in amounts: #120 methadone, #180 OxyContin, #300 Norco, and #180 Soma. It is a violation of the standard of care to increase the dosages of multiple drugs at one time. Doing so prohibits a determination of effectiveness of the regimen.

172. On December 18, 2009, RB reported that the methadone was making him sleepy and he requested a medication for "nerve pain instead." His pain level was 8/10 with a reference to cold weather, and at best 1/10. Respondent prescribed Elavil, which he testified works differently for pain than it does for depression. He issued the following prescriptions: #120 methadone, #180 OxyContin 80 mg, #300 Norco, #180 Soma and 48 oz PCCS, and 50 mg Elavil. The starting dose of Elavil was excessive and too sedating for RB. The normal dose would be 25 mg taken at bedtime.

173. During one of the years that Respondent was treating RB, RB was also obtaining Norco from two other physicians. Respondent blamed his lack of knowledge of this fact on late CURES reports, and claimed that he "took action" when he learned about it.

174. RB testified that Respondent "ordered blood tests for me every time I came in" and that they discussed the results. The tests were to check his liver, and to see if he was taking the medications. In addition, RB stated that urine screens were conducted. Respondent acknowledged that this testimony was untrue.

175. Respondent treated RB for approximately 28 months. Despite his knowledge that RB had lied on multiple occasions, a urine screening test was never ordered or obtained. Respondent obtained one liver function test, on March 13, 2009, following an interview by a Board representative.

176. Between May 9, 2009 and July 3, 2009, Respondent prescribed over four grams daily of acetaminophen daily to RB, a potentially toxic level.

177. The following treatment of RB by Respondent constituted gross negligence:

a. Failing to perform an adequate history and physical examination, particularly as regards past alcohol and drug abuse.

b. Failing to adequately assess RB's psychological functioning.

c. Prescribing excessive amounts of Soma, Xanax and PCCS without a substantiated diagnosis or medical indication.

d. Failing to warn RB of the hazards of excessive amounts of acetaminophen, including the amount that was contained in his prescription medications, and of the risk of adding to those amounts by taking over-the-counter drugs containing acetaminophen.

e. Failing to obtain and document informed consent from RB for the course of treatment.

f. Failing to conduct meaningful periodic reviews of RB's progress, including by obtaining random drug screens and/or a CURES patient activity report.

g. Diagnosing spondylolisthesis without a documented physical examination and objective findings to support the diagnosis.

178. The following treatment of RB by Respondent constituted negligence:

a. Failing to document a treatment plan.

179. Respondent was incompetent in his care of RB in that he demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology. The incompetent care included, but was not limited to: prescribing more than four grams of acetaminophen daily for a period of time; rapidly escalating the dosage of OxyContin; and prescribing PCCS for sleep.

180. Complainant alleged that Respondent was guilty of unprofessional conduct for failing to refer RB to an orthopedic specialist. It was not established that such referral was required by the standard of care; therefore, this allegation was not proven.

PATIENT LR

181. On November 23, 2007, Respondent first saw patient LR, a female age 40. He noted that she was five feet, three inches tall, weighed 230 pounds, and complained of pain in both knees. LR told Respondent that her knee pain derived from a car accident five years prior and that she preferred to not have surgery. She had moved to California in 2003 and had been buying medications "on the street" for two years. (It does not appear that Respondent inquired as to what medications were purchased.) LR also told Respondent that she had never abused drugs, but that her husband had done so and was in his third year of a nine-year prison sentence for fracturing her jaw. Respondent noted some difficulties communicating and "bronchitis cough for two weeks," with treatment in the emergency room.

Respondent noted that LR was not able to flex her knees more than ten degrees. Although this would logically have prevented LR from even sitting in a chair, there was no further note regarding this finding. He also found no looseness or swelling in the knees. Respondent's impressions were: "internal derangement of knees, osteoarthritis of knees, scoliosis of thoracic spine and chronic pain syndrome." Respondent referred LR for an x-ray of her knees and a chest x-ray as regards the scoliosis issue. He prescribed #240 Vicodin ES, #240 Soma 350 mg, and 32 oz PCCS.

182. On December 14, 2007, LR returned and reported pain in both knees that was worse in the left. Her x-rays had not been done. Respondent refilled the same prescriptions.

183. On January 11, 2008, Respondent noted that LR's purse was stolen with the x-ray report inside. She was wheezing, had a runny nose and reported a knee pain level of 8/10. LR told Respondent that she had "used up her meds in 3 weeks." There is no note to indicate whether Respondent inquired further about this statement. Respondent requested x-rays again. Still without results, and without further examination or medical indication, Respondent increased the prescription amounts. He prescribed #300 Vicodin ES, #300 Soma and 32 oz PCCS.

184. On February 7, 2008, x-rays of LR's knees were taken at Doctors Medical Center. The x-rays revealed mild degenerative changes which did not objectively support the pain complaints. On February 8, 2008, Respondent noted that he "suspects" osteoarthritis. He testified that he was still awaiting the x-rays. He prescribed the same medications, and added, without medical indication, #120 Valium 10 mg. Respondent testified that this was in part for anxiety and also for "muscle spasms in the calves."

185. Respondent did not see LR again until April 18, 2008. He noted that she had fallen down stairs, and had increased pain in her right buttock, with the worst pain level 10/10 and best 0/10. Respondent also noted "'Momma' gave her some OxyContin 80 mg, one dose [illegible] that helped her. Will decrease Vicodin start OxyContin." Respondent prescribed #120 OxyContin, #120 Vicodin, #120 Soma 350 mg, #120 Valium 10 mg, and 32 oz PCCS.

He also noted that there were no x-rays of the knees or chest in his file, and that the patient was to have them done and the reports sent to him before he would prescribe further.

186. On May 16, 2008, Respondent noted receipt of x-ray reports that showed mild degenerative changes in both knees. His plan was to wean LR off of OxyContin and refer her for an orthopedic consult. Respondent prescribed the same medications, but cut the OxyContin in half, which was a dangerous decrease in dosage.

187. On June 12, 2008, Respondent noted that LR had fallen down three steps and had pain in her left ankle. He advised her to go to the emergency room. Respondent noted LR was to return in four weeks, but refilled her prescriptions "times two."

188. On July 11, 2008 and August 7, 2008, Respondent refilled LR's prescriptions. The August 7 note states that LR was not able to keep her appointment for the next day because she was going to Arizona.

189. Respondent received a CURES activity report concerning LR with a date range between October 1, 2006, and October 17, 2008. His records indicate he reviewed it on October 17. The report shows that, in 2008, LR received prescriptions for APAP/hydocodone bitartrate (Vicodin) from two other physicians and a prescription for Roxicet from one other physician. LR used pharmacies other than those she utilized to fill prescriptions from Respondent.

190. On October 31, 2008, LR signed a Patient Testimonial form maintained by Respondent attesting that she had not obtained pain medications from any other source. Respondent noted that when he asked LR where in Arizona she had traveled to, she was "unable to answer [a] simple question." LR telephoned someone to find out where she had gone. LR became very angry. Respondent noted that she was "dissatisfied with coming here because I ask her questions she can't answer." He quotes her as saying "don't do me no good anyway," that she was shouting, and that she asked for her money back and slammed the door. In addition, LR said "he ain't no real doctor anyway," and shouted to Respondent's secretary "He's going to be sorry here not me." Respondent noted that she "left the office shouting to me that I'm going to die." No prescriptions are noted.

Respondent testified in detail about this appointment. By asking LR about Arizona, he was trying to find out if she was being truthful with him, but also because "maybe her mentation is that she doesn't understand instructions and maybe I shouldn't be treating her." Respondent noted that LR told him she sometimes gives medication to others who are in pain, including a sister, who was also his patient. Respondent did not know which sister she was referring to. Respondent explained that he was not sure of what was going on in LR's life, but that she was violating his rules by giving her medications to others. On the other hand, he believes that she was showing a lot of improvement in her activities. Respondent felt that he asked her too many questions "and she exploded." He felt "between a rock and a hard place," and thought that he would "continue to see her so that I could iron that matter out."

191. In a note dated December 11, 2008, Respondent wrote that another patient, LW, accused LR "of absconding with his medication." On December 17, 2008, LR brought her sister with her to the office, to provide support for LR's assertion that LR had given LW his medications at the pharmacy, and that she was "innocent." To Respondent's understanding, LR and her sister were helping LW, who did cooking for them. They would go to the pharmacy, her sister would pay for the prescriptions for both of them, and then give LW his medications.

Respondent testified that he was concerned at this point that, because LR reported going to the emergency room three times for pain, he "might not be treating her adequately." He was not sure if the pain was "her fault or mine," and that her anger at not being able to answer questions might be due to a learning disability.

192. Despite the matters described above, LR's untruthfulness, and the scant evidence that her knees were in such condition as would cause the level of pain that she described, Respondent continued to treat LR by prescribing narcotics and dangerous drugs.

193. On December 17, 2008, LR informed Respondent that she was told at the emergency room that she had gout. On January 15, 2009, LR reported pain at the worst of 10/10 at the bottom of her feet and her ankles. Respondent was concerned about LR's ability to understand the directions for taking medication. LR reported that Dr. Malcolm Johnson was treating the gout and had ordered lab work.

194. On February 11, 2009, LR informed Respondent that she was pending surgery for carpal tunnel syndrome, which was discovered by Dr. Johnson. This is the first he had heard of this complaint. He wrote "I am the only one giving her pain meds." There is no indication that Respondent contacted Dr. Johnson, or any other physician treating LR. Respondent prescribed #60 OxyContin, #120 Vicodin ES, #120 Soma, and 32 oz PCCS.

195. On March 11, 2009, Respondent's notes appear to indicate that LR does not understand when to take her medications. He quotes her as saying "I'm not really good in math" and notes that she did not finish school. Nonetheless, he noted "refill meds of 2-11-09."

196. On March 14, 2009, LR called to say that her purse, which contained her prescriptions, was stolen. Respondent also noted that Walgreens had called to report that someone brought in a prescription for LR with the number 60 changed to 160. Respondent's office manager told them not to fill it. Respondent followed up the next day by calling and asking for a description of the customer; it is unclear whether he obtained a description.

197. On April 1, 2009, there is a long note describing the alleged theft of LR's purse at a birthday party. Respondent ends the note by concluding that LR has not been truthful and that she and a friend, who Respondent had refused to give OxyContin, changed the 60 to 160 in order to get OxyContin "probably to sell." Respondent wrote that he "dismissed the pt - offered a list of pain MDs."

198. The following treatment of LR by Respondent constituted gross negligence:

a. Failing to perform an adequate history and physical examination.

b. Failing to adequately assess LR's psychological functioning.

c. Prescribing excessive amounts of Vicodin, Soma, Valium and PCCS without a substantiated diagnosis or medical indication to support prescribing each medication.

d. Failing to obtain and document informed consent from LR for the course of treatment.

e. Failing to conduct meaningful periodic reviews of LR's progress, including by obtaining random drug screens and/or sufficient CURES patient activity reports.

f. Failing to tailor his pharmacological treatment to treat the diagnosis of "internal derangement of knee with osteoarthritis" and failing to respond to physical examination findings that did not match the patient's pain complaints.

199. The following treatment of LR by Respondent constituted negligence:

a. Failing to document a treatment plan.

b. Failing to consult with other physicians concerning the care and treatment of LR.

200. Respondent was incompetent in his care of LR, in that he demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology. The incompetent care included, but was not limited to: starting LR on excessively high levels of Vicodin ES and Soma; failing to take action when he learned that LR was receiving opiates from several different physicians; and prescribing PCCS for sleep.

PATIENT LW

201. On February 8, 2008, Respondent first saw LW, a 52-year-old male. LW informed Respondent that he had suffered lye damage to his esophagus, that he used to smoke marijuana, and that he had been to jail for petty theft 15 years ago. His pain complaints concerned his mid-back and left shoulder. Respondent diagnosed failed left shoulder surgery and cervical and lumbar spondylosis. There is no note as to what medications LW had previously been taking. Respondent prescribed #60 MS Contin 200 mg, #240 Vicodin ES, #180 Soma 350 mg, #30 Lidoderm patches, #120 Valium 10 mg, and 16 oz PCCS. Later the same day, LD reported that he had lost the MS Contin prescription, and Respondent replaced it. Respondent prescribed the above listed medications without medical indication.

202. On March 7, 2008, LW told Respondent that he was not working, was living temporarily with a friend, and was being treated by a psychiatrist for bipolar disorder. He revealed that the psychiatrist prescribed Seroquel (an anti-psychotic drug) but that he did not regularly take it. Respondent continued the same prescriptions. Respondent did not then, or at any time during the course of treating LW, attempt to or contact LW's treating psychiatrist or obtain his psychiatric records. In addition, there is no indication that Respondent adjusted the medication regimen in consideration of the reported mood disorder or the fact that he was taking, if not regularly, an anti-psychotic medication.

203. On April 11, 2008, LW reported that he had been arrested for loitering on March 26, 2008, and had another person's identification. LW was incarcerated for 16 days and was released on probation. Respondent discontinued the MS Contin at this visit, noting that it cost $300 and that LW had not obtained any. LW had obtained OxyContin in the past from a friend; therefore, Respondent replaced the MS Contin with #60 OxyContin 80 mg. He also increased the PCCS to 32 oz, and continued the same prescriptions for Vicodin ES, Soma and Valium. He wrote "psychiatrist" and "'mood swings'" in the note for that day.

204. On May 16, 2008, Respondent noted that LW was "doing well psychiatrically," but that he "ran out of medication." Pain was at best 0/10 and at worst 8/10, mostly in the Mid-body and left shoulder. Respondent increased the OxyContin to #120, and issued three months' worth of the medications he had prescribed in April.

205. On July 25, 2008, Respondent claimed that he had run out of medications "a week or two ago when he took extra medication for his burn injury." Although the May prescriptions should have lasted until mid-August, Respondent issued prescriptions for #60 OxyContin, #240 Vicodin ES, #180 Soma, #120 Valium, and 32 oz PCCS.

206. On July 30, 2008, Respondent noted a telephone call from LW reporting that he "forgot his teeth and medications on a bus." Respondent requested that LW come to the office, then at 2:45 p.m. noted that LW was "here." After confirming that LW had made a call to 911 about the incident, Respondent refilled the medications. The note goes on to state "pt called an ambulance . . . and was kept in hospital 2 days. Was referred to mental health for mood swings. Placed on Seroquel - Trazadone - short time: went to clinic for follow up. He claims the 'ladies all like' him. Exercises explained for strengthening spine—nourishing joints." On a separate page with the same date, Respondent wrote an extensive note stating that LW "states he's had mood swings." Also, there are reports of a criminal history that includes 30 days in jail for assaulting a woman two years before. There is a note "Seroquel, later Trazadone." No physical examination is noted.

207. On August 22, 2008, Respondent prescribed a set of medications for LW including two refills; a total of three month's worth. The prescriptions were: #240 Vicodin ES, #240 Tylenol No. 4, #200 Soma 35 mg and 32 oz PCCS. This combination of Vicodin and Tylenol (eight pills each per day) contained a daily dose of over eight grams of acetaminophen, which is a toxic dose. The records do not document that informed consent was obtained and that LW was warned about the dangers of taking that dosage or about the dangers of also taking

over-the-counter medications that contained acetaminophen at the same time.

208. On November 12, 2008, Respondent refilled the Vicodin ES, Soma and PCCS prescriptions.

209. On December 2, 2008, Respondent noted that LW told him that patient LR had picked up his prescriptions at his request, but that she did not give him the medications. On December 11, Respondent noted that he called the pharmacy and stated that only LW was to pick up his prescriptions. On December 17, he noted that patient LR stated that she paid for LW's prescriptions and handed them to him. LR also told him that LW had been stealing syringes and using street drugs, among other things. Respondent wrote "I'll terminate his service here." But he continued to treat LW.

210. On January 7, 2009, Respondent noted that LW "has no signs that he is shooting drugs." LW reported that he is attending church twice weekly and that he gets along well with his sister and his brother-in-law, who is a minister. Respondent prescribed #240 Vicodin ES, #240 Tylenol No. 4, #200 Soma and 32 oz PCCS. The combination of medications resulted in a toxic level of acetaminophen.

211. On January 23, 2009, Respondent noted "Emergency Rx pt in pain." He prescribed #180 Vicodin and 32 oz. PCCS. On February 4, less than two weeks later, Respondent noted reported pain levels of 10/10 at worst, 1-2/10 at best, and 4-5/10 on an average day. He prescribed #180 Norco 10/325, #240 Tylenol No. 4, #240 Vicodin ES, #240 Soma and 32 oz PCCS. The prescribed daily doses contained almost 11 grams of acetaminophen, which was a toxic amount.

212. On March 4 and March 27, 2009, Respondent refilled LW's medications, which continued to contain toxic levels of acetaminophen.

213. On April 24, 2009, Respondent noted several statements by LW that together give rise to mental health concerns. These include that he ran into a doorknob while being chased by another man over a woman; that he was a lady's man, in part because his astrological sign is Leo/Cancer making him "double trouble"; that he "smokes weed a little bit"; that he is "no longer doing crack because he "told Jesus I had a problem"; and that he is a "messenger of God . . . I know I am." LW also reported that he had injured his hip and was taken to the hospital by an ambulance. Respondent increased the Norco to "20 pills for the recent injury" and refilled the other prescriptions. The same prescribing continued on visits on May 22, June 12, July 10 and August 4.

214. On September 4, 2009, Respondent prescribed #320 Norco, #240 Vicodin, #120 Valium, #200 Soma and 48 oz PCCS. On September 9, Respondent noted a report that LW had been hospitalized with a confused mental state. He wrote: "pt took a couple Valiums to calm himself when he became excited . . . and when he took a Soma he became confused - mentation changed. Friend called an ambulance." LW was incarcerated briefly after he was discharged, and it appears that he told Respondent that he no longer had his medications. In sum,

Respondent received direct information that LW was taking Valium to calm himself (not for pain) and that he was confused sufficiently to warrant hospitalization after taking a Soma as well. Respondent refilled the prescriptions without further comment in the note.

215. On October 7, 2009, Respondent refilled LW's medications. On October 14, LW reported that all but two of the medications were stolen on October 7. Respondent prescribed #120 OxyContin 80 mg and #240 Tylenol No. 4. On October 30, LW reported that he "got jumped" and had been knocked unconscious for a few minutes. Respondent refilled the medications.

During October 2009, Respondent prescribed to LW a total of #60 MS Contin 100 mg; #240 OxyContin 80 mg; #960 Norco; #720 Vicodin ES; #480 Tylenol #4; #600 Soma, and 192 oz (one and one-half gallons) of PCCS. The daily doses contained toxic levels of acetaminophen sufficient to kill most patients, leading to the reasonable inference that, in addition to the amounts prescribed, LW was not taking all of these medications and was either giving them away or selling them.

216. On January 8, 2010, Respondent noted that LW had fallen and injured his right shoulder. He concluded that LW had "mild impingement [and] exaggerated response." Respondent informed LW that he would need to find another physician. He gave LW three months' worth of prescriptions to help him during the transition.

Respondent testified that he released LW after concluding that he was "trying to pretend . . . fool me . . . about his shoulder." Respondent also stated that he concluded LW was exaggerating the pain in his shoulder when he saw him use his right arm to write with. He finally concluded that the case was "too complicated for me to handle."

217. The following treatment of LW by Respondent constituted gross negligence:

a. Failing to perform an adequate history and physical examination.

b. Failing to adequately assess LW's psychological functioning.

c. Prescribing excessive amounts of controlled substances and dangerous drugs without a substantiated diagnosis or medical indication to support prescribing each medication.

d. Failing to obtain and document informed consent from LW for the course of treatment.

e. Failing to conduct meaningful periodic reviews of LW's progress, including by obtaining random drug screens and/or a CURES patient activity report.

f. Failing to consult with a psychiatrist concerning LW's care.

g. Failing to refer LW, who had been diagnosed with a mental health disorder; had been prescribed anti-psychotic medications; had a history of criminal behavior and substance abuse; and who had revealed continuing problems to Respondent over the period of treatment, to another pain specialist for treatment.

h. Prescribing medications for LW where the daily dosage contained a toxic amount of acetaminophen.

i. Failing to warn LW of the hazards of excessive amounts of acetaminophen, including the amount that was contained in his prescription medications, and of the risk of adding to those amounts by taking over-the-counter drugs containing acetaminophen.

218. The following treatment of LW by Respondent constituted negligence:

a. Failing to document a treatment plan.

219. Respondent was incompetent in his care of LW, in that he demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology. The incompetent care included, but was not limited to: prescribing more than four grams of acetaminophen daily for a period of time; prescribing PCCS for sleep; and increasing the amounts of various medications without medical indication.

PATIENT DC

220. On September 11, 2008, Respondent first saw patient DC, an 81-year-old male. DC's niece was with him and helped explain his history. DC complained of left leg pain following a gunshot wound three years previously. DC also complained of pain in his low back, and neck pain radiating to his left shoulder. In general, he rated his pain level as 9/10. DC also suffered from diabetes and experienced numbness in both feet. DC could not read. He had been a laborer and spent approximately eight months in jail at some point in his life. Respondent noted difficulties with memory and making calculations. DC had been taking Tylenol No. 4, Vicodin, and diabetes and cholesterol medications. Respondent's impressions were a gunshot injury in the left lower extremity, cervical and lumbar spondylosis, and diabetic neuropathy.

221. At this first visit, Respondent prescribed #240 Vicodin ES, #240 Tylenol #4, #120 Valium 10 mg, #240 Soma, 32 oz PCCS, and #60 Cymbalta 60 mg. The combination of eight tablets daily of both Tylenol #4 and Vicodin ES resulted in a daily dose of approximately 8.4 grams of acetaminophen. This is a toxic level far in excess of the generally recommended maximum daily limit of four grams. There is no indication in the notes that DC was warned about the possible effects of large doses of acetaminophen.

Respondent's prescription for Cymbalta 120 mg per day was far in excess of 30 mg per day, which is the maximum starting dose for patients over 65 years of age. The prescriptions for both Tylenol No. 4 and Vicodin ES were not warranted. They are essentially the same

compounds of hydrocodone. And, they are the last choice for neuropathic pain and not warranted because of the trial of Cymbalta. There was no medical indication for the prescribing of PCCS, Valium or Soma. All are sedating medications particularly inappropriate for an elderly patient with possible dementia.

222. On October 10, 2008, Respondent noted that DC reported that the Cymbalta did not help the numbness and leg pain. Respondent discontinued Cymbalta. He prescribed Vitamin B12, #60 OxyContin, #240 Vicodin ES, #240 Tylenol No. 4, #240 Valium 10 mg, #120 Soma 350 mg, and 32 oz PCCS. There was no medical indication for prescribing OxyContin, which is not helpful to treat neuropathic pain. The amount of OxyContin exceeded the standard protocol for titration of opiates.

223. On November 7, 2008, DC reported that the pain level in his legs at worst was 10/10. Respondent noted that the Vitamin B12 was "not helping the pain in his feet." The note is unclear as to whether DC was to continue to take it. Vitamin B12 has been shown to help treat neuropathy, but one month is not an adequate therapeutic trial. Respondent discontinued OxyContin, and added #120 MS Contin with no rationale for doing so. He also prescribed Norco 10/325, #180 Soma 350 mg, #90 Tylenol No. 4, and 32 oz PCCS.

224. On January 30, 2009, DC reported that he never obtained either the OxyContin or the MS Contin. The pain level was at worst 5/10 and best 0/10. It is again noted that Vitamin B12 was not helping, and Respondent discontinued it, along with the OxyContin and MS Contin. Respondent increased Tylenol No. 4. He prescribed #240 Vicodin ES, #240 Tylenol #4, #240 Soma 350 mg, #240 Valium and 32 oz PCCS. The prescribing was done without medical indication, and in amounts containing toxic levels of acetaminophen. In addition, the amount of Valium prescribed, eight tablets per day, even taken alone, could be a fatal dose.

225. On April 17, 2009, Respondent notes that DC "was doing even better," but requested OxyContin in order "to reduce the 240 pills x 4 he is taking." Respondent prescribed #60 OxyContin 80 mg, but he also refilled the other prescriptions. He also issued sequential prescriptions dated May 14, 2009, and June 12, 2009. The prescriptions were issued without medical indication.

226. On July 10, 2009, Respondent noted that DC's pulses were not palpable and that color returned to the toes slowly. His impression was vascular insufficiency and peripheral neuropathy in connection with diabetes. He prescribed #60 OxyContin, #240 Vicodin ES, #240 Tylenol No. 4, #240 Soma, #180 Valium and 32 oz PCCS. Respondent issued sequential prescriptions dated July 10, August 7 and September 4, 2009.

227. On October 2, 2009, Respondent saw DC for the last time. DC reported the worst pain to be in his left foot. Respondent notes that DC "doesn't comprehend the pain scale," but also that he "prefers Norco over Vic ES." Respondent refilled the previous medications, except that he substituted Norco for Vicodin ES, and issued sequential prescriptions for October 2, October 30 and November 27, 2009.

228. The following treatment of DC by Respondent constituted gross negligence:

a. Failing to perform an adequate history and physical examination.

b. Prescribing excessive amounts of controlled substances and dangerous drugs without a substantiated diagnosis or medical indication to support prescribing each medication.

c. Failing to obtain and document informed consent from DC for the course of treatment.

d. Failing to conduct meaningful periodic reviews of DC's progress, including by obtaining random drug screens and/or a CURES patient activity report.

e. Failing to refer DC to a neurologist or other pain specialist and or to consult with a neurologist or other physician concerning DC's care.

f. Prescribing medications for DC that negatively impact cognition in disregard of DC's reduced cognition.

g. Prescribing medications for DC where the daily dosage contained a toxic amount of acetaminophen.

h. Failing to warn DC of the hazards of excessive amounts of acetaminophen, including the amount that was contained in his prescription medications, and of the risk of adding to those amounts by taking over-the-counter drugs containing acetaminophen.

229. The following treatment of DC by Respondent constituted negligence:

a. Failing to document a treatment plan.

230. Respondent was incompetent in his care of DC, in that he demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology. The incompetent care included, but was not limited to: failing to recognize that a starting dose of 60 mg Cymbalta is generally not well tolerated in an older man; prescribing a combination of medications that decrease cognitive functioning; and prescribing medications in excessive doses and without medical indication; and prescribing PCCS for sleep.

PATIENT GB

231. Patient GB was first seen at Redwood on August 13, 2003, by a different physician. He was 55 years old at that time. His complaints were of pain in his back, knee and foot. GB also reported that he had Hepatitis C and that he was married to patient DS. The records are very difficult to read, and there does not appear to be a diagnosis noted. GB signed

a treatment agreement that did not include information sufficient to constitute informed consent. He was prescribed controlled substances. In late August 2003, GB was incarcerated.

232. Respondent first saw GB on February 16, 2004. He had been released from jail on January 22. Respondent noted that GB had suffered low back pain while in jail that resulted in confinement in the infirmary for two months. GB complained of low back pain radiating to his left leg. He was using a wheelchair, and was scheduled to see a neurologist in two days. No physical examination is noted and Respondent did not obtain any of GB's medical records. Respondent's impression was lumbosacral sprain, cervical sprain, and degenerative disc disease. He prescribed #180 Vicodin ES, #180 Soma, #90 Norco 10/325 mg, and #30 Valium 10 mg.

There was no medical indication for prescribing Vicodin ES and Norco at the same time, as both are short acting combinations of hydrocodone and acetaminophen. There was no medical indication for prescribing both Soma and Valium. These drugs are highly sedating and it was dangerous to prescribe them both to GB.

233. On March 8, 2004, just three weeks later, Respondent refilled the prescriptions in the same amounts. The dosages contained in excess of seven grams of acetaminophen, a toxic amount, particularly for a patient with Hepatitis C. The daily acetaminophen dose for such patients should not exceed two to three grams. On April 1, 2004, again after just three weeks, Respondent refilled the prescriptions.

234. On April 26, 2004, Respondent notes that GB was wheelchair-bound. He was being treated by a neurosurgeon with Dexamethasone, a steroid, to help relieve nerve compression caused by his disc disease. Respondent made significant changes to the medication regimen on this visit. He prescribed #90 Vicodin ES, #180 Norco (switching the previously prescribed amounts of these two drugs), #240 Soma and #30 Valium. The notes contain no rationale for these changes.

235. On May 12, 2004, GB underwent a T10-11 decompressive laminectomy, and his neurosurgeon prescribed medications for several months thereafter, including Norco, Vicodin and Soma. Respondent continued to see GB monthly and to prescribe medications. Respondent increased Valium from #30 to #60 to #90 tablets. On November 24, 2004, Respondent discontinued Vicodin ES and added #90 Percocet. On January 17, 2005, Respondent added 16 oz PCCS, with no reason indicated in the notes.

236. On September 19, 2005, GB reported to Respondent that he had been hit by a car while in his wheelchair. Respondent noted that GB "was shaken up" but that there were no abrasions or tenderness in his lower extremities, and some tenderness in the low back. He also noted that symptoms would possibly develop, and also that the pain level was severe. Respondent noted that the program was to continue with present pain management, but increased Norco to #300 tablets.

237. On October 17, 2005, Respondent added #120 methadone 10 mg. There was no medical indication for the prescription. Further, GB was already receiving methadone from his primary care physician. A CURES report reveals that GB had received #125 to #135 methadone 10 mg monthly from December 2004 through November 2005. Respondent was unaware of these prescriptions.

238. On November 17, 2005, Respondent noted that GB was "doing better following recent accident." He prescribed #120 Valium 10 mg, #120 Percocet 5/325, #240 Soma 350 mg, #300 Norco 10/325, #120 methadone 10 mg and 16 oz PCCS. This prescription included six sedating medications, and four of them affect the same pain receptors.

239. Beginning with a note on March 2, 2006, Respondent mentions "Cannabis for muscle spasms." He apparently began recommending medical marijuana at about this time. He executed a physician's recommendation on March 31, 2006, that stated he was treating GB for spinal stenosis. Marijuana use was not medically indicated and was risky for GB, who was receiving multiple prescriptions for habit-forming medications and had a history that included Hepatitis C and incarceration. On the same date, PCCS was increased to 32 oz.

240. In December 2006, Respondent increased Valium to #200 and methadone to #300 without medical indication. In August 2007, he added a 100-microgram Duragesic patch, a very powerful medication, to be changed every three days. Respondent testified that the Duragesic prescription was the result of his convincing GB to take a sustained release medication. But Respondent did not adjust the other prescriptions. On March 28, 2008, Respondent discontinued Duragesic and on April 25, 2008, increased Valium to #300.

241. On June 20, 2008, Respondent gave GB refills of his prescriptions dated July 18, August 14, and September 12, 2008. GB was not a good candidate for sequential prescriptions, for reasons including his history of receiving medications from multiple providers.

242. The medications prescribed by Respondent for GB, if taken as prescribed, constituted a toxic dose of acetaminophen for a patient with Hepatitis C. In November 2005, for example, if GB took the medications prescribed over a 23-day period, he received approximately five and one-half grams per day, a dosage in excess of the two and one-half grams per day recommended maximum. Further, GB had been prescribed acetaminophen-containing medications by his neurosurgeon. Respondent did not know of the medications prescribed by other providers.

243. The following treatment of GB by Respondent constituted gross negligence and incompetence:

a. Failing to obtain medical records of GB's prior treatment to evaluate GB's risk for substance abuse.

b. Prescribing unconventional medications at high doses.

c. Failing to create and document a treatment plan and strategy to deal with GB's addition potential.

d. Failing to refer GB to an addiction specialist.

e. Prescribing medications for GB where the daily dosage contained a toxic amount of acetaminophen.

PATIENT DS

244. Patient DS, then age 55, was seen at Redwood by another physician on July 30, 2003. She is married to patient GB, and presented with complaints of pain in her neck, leg, and low back. The history taken at that time included that she had hepatitis, and that she was taking Vicodin, Soma, and Norco, as well as Percocet, which she "buys off the street." She was diagnosed with osteoarthritis of both knees, lumbosacral strain with degenerative disc disease, and shoulder pain, and prescribed Motrin 800 three times daily, #240 Norco, #120 Soma, and #30 Elavil 25 mg. It is also noted in the record that DS had an "addictive personality."

245. On September 10, 2003, Respondent saw DS for the first time. He documented a physical examination and continued the prescription regimen, although he reduced the Motrin to twice daily.

246. Neither the original physician nor Respondent obtained DS's prior treatment records, documented a strategy to deal with her addiction potential, or referred her to an addiction specialist. No informed consent or treatment agreement was obtained.

247. On October 8, 2003, Respondent replaced the Elavil with #90 Valium 10 mg. On October 29, less than three weeks later, Respondent added #120 Percocet, reduced the Norco to #90, increased the Soma to #180, and continued the #90 Valium. He did not document any reason for these changes. DS subsequently told Respondent that she did not fill the Percocet prescription.

248. On May 24, 2004, no physical examination is noted. Respondent added #90 Roxicet 5/325 mg to DS's medications, without medical indication. On August 16, 2004, he substituted #90 Percocet 5/325 for the Roxicet. On November 4, 2004, he added PCCS 16 oz to DS's medication regimen, without explanation or medical indication. On January 17, 2005, Respondent noted that DS was "improving with the pool therapy – it gets her loose." He increased the Percocet to 120 tablets without medical indication.

249. On April 11, 2005, Respondent did not perform a physical examination. Pain levels were recorded as 6/10, down from 8/10 in February. He increased the amounts of three medications: Soma from 180 to 240; Valium from 90 to 120, and Norco from 200 to 240, without medical indication.

250. On September 19, 2005, Respondent noted that DS had a new injury. She was in the same accident as her husband GB; when a car hit his wheelchair, DS fell on GB. Pain was noted as "severe," and her prescriptions were refilled. Respondent examined DS, and noted bruising and tenderness. On October 17, 2005, Respondent increased Norco to #300 and added #120 methadone 10 mg. (This is the same date that Respondent added methadone to GB's medication regimen.)

251. During 2004 through 2006, DS also filled prescriptions from other providers, and at different pharmacies. Her cardiologist prescribed Soma. Another doctor prescribed Valium. Her primary care physician prescribed Roxicet and methadone. She also received prescriptions from others for PCCS and Norco. Respondent's notes indicate that he was aware that DS had other health care providers, including a cardiologist; he had noted that the cardiologist was prescribing Warfarin. But there is no indication that Respondent communicated with other physicians concerning DS. Respondent testified that he did not know about the other prescriptions.

252. On February 2, 2006, Respondent increased Valium to #180, Soma to #300, and PCCS to 32 oz. On March 2, 2006, he discontinued Percocet and increased methadone to #240. These prescriptions were without medical indication.

253. On March 31, 2006, Respondent provided DS with a recommendation for marijuana based upon the condition "severe osteoarthritis." (This is the same day he provided a marijuana recommendation for her husband, GB.)

254. On August 18, 2006, Respondent increased Valium to #200, and on November 10, 2006, increased methadone to #300. Respondent continued to see DS monthly, evaluating her pain levels and functioning, and prescribing the same medications through June 20, 2008.

255. Meanwhile, on April 18, 2008, Respondent noted that DS had tested positive for cocaine use twice while hospitalized for a rectal ulcer. He did not discuss these results with DS. He did not coordinate care with any other physician. On June 20, 2008, Respondent scheduled a return visit on September 12, 2008, and issued sequential refills of her prescriptions for July 18, August 15, and September 12, 2008.

256. Respondent testified that he had "excellent rapport with this patient." He felt that they "hit it off very well." He opined that he was good with all of his patients, but with DS, it was "a little bit more." Respondent also offered that DS and GB did not really like taking medications. For example, they "resisted the sustained release medications as they heard bad things" about them although they "eventually came around."

Respondent also testified, however, that he was unaware that DS was receiving prescriptions from other providers for the same medications that he was prescribing. This representation not only contradicts his belief that he enjoyed an "excellent rapport" with DS, but demonstrates that he was practicing without necessary information, as he did not order a

CURES report or investigate whether DS was receiving prescriptions from other doctors. Even when advised that she had used cocaine, he did not change his treatment regimen.

257. The marijuana recommendation was given without medical indication and was contraindicated by multiple risk factors. DS had a history of buying Percocet "off the street"; a note in the record opined that she had an "addictive personality"; she had used different pharmacies; she was receiving multiple medications for high doses of sedative hypnotic drugs (including from different prescribers); she twice tested positive for cocaine while hospitalized; and her husband was receiving similar medications and dosages.

258. The following treatment of DS by Respondent constituted gross negligence and incompetence:

a. Failing to obtain medical records of DS's prior treatment to evaluate DS's substance abuse history.

b. Prescribing unconventional medications at high doses.

c. Failing to obtain and document informed consent from DS for the course of treatment.

d. Failing to create and document a treatment plan and strategy to deal with DS's addiction potential.

e. Failing to refer DS to an addiction specialist.

Patient testimony in support of Respondent

259. Respondent told his patients that if they wished to express their opinion, they could write a letter that he would submit in evidence "to give them a voice." Subject patients WR and RB both testified, and wrote supportive letters. Two other patients testified and wrote letters (RN and RH), and an additional two patients testified (SD and CW).

There were significant differences between the care and office practices described by the patients who testified and wrote letters, and what was documented in the records of the eleven patients. The major difference involved periodic reporting and testing. One patient testified that she filled out a patient testimonial form at every visit, that she was a Kaiser patient as well, and had liver function tests performed at Kaiser every two months that she shared with Respondent. Another patient testified that Respondent required urine drug screens "to make sure that the side effects didn't do more harm than good." This included kidney and liver function tests, because he was taking Norco. Another patient said that he had a blood panel test every three months to make sure that his liver and kidneys "were functioning without any problems." Another patient testified that Respondent ordered blood and urine tests "every couple or three months" to "make sure that my liver was working good because of the Tylenol content of the medications." In all, five of the six patients who testified claimed that they filled

out a patient testimonial form at every visit, including WR and RB, whose records each contain only, respectively, two and three testimonial forms. The assertions and descriptions of the supportive patients were in contrast not only to the records of the eleven patients at issue, but with Respondent's own descriptions of his practice.

It is recognized that all of the patients who testified were very pleased with the care they received from Respondent and it was clear that they desired that he continue practicing. But they offered very little credible, relevant evidence.

Continuing education

260. In March 2012, Respondent completed two continuing medical education courses sponsored by the Western Institute of Legal Medicine: Prescribing Practices and Management of Substance-Abusing Patients, and Medical Record Keeping. Respondent testified that he "learned right off the bat" from these courses that his method of issuance of sequential prescriptions was not correct. He also learned that he needed to be more complete in his documentation, including of the "initial work-up," that informed consent needed to be "more explicit," and that hospitals are obligated to give him medical records when he asks for them. Respondent represented that he learned "a lot of helpful things" at the courses.

LEGAL CONCLUSIONS

CAUSES FOR DISCIPLINE

1. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes violating provisions of the Medical Practice Act (Bus. & Prof. Code, § 2234, subd. (a)), gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)), incompetence (Bus. & Prof. Code, § 2234, subd. (d)), prescribing dangerous drugs without an appropriate prior examination and a medical indication (Bus. & Prof. Code, § 2242, subd. (a)) and violating federal or state laws regulating dangerous drugs or controlled substances (Bus. & Prof. Code, § 2238). In addition, unprofessional conduct includes "Repeated acts of clearly excessive prescribing, furnishing, dispensing or administering of drugs . . ." (Bus. & Prof. Code, § 725, subd. (a)) and failing "to maintain adequate records (Bus. & Prof. Code, § 2266).

Gross negligence

2. The evidence established that Respondent committed gross negligence. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (b).

Repeated negligent acts

3. The evidence established that Respondent committed repeated negligent acts. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (c).

Incompetence

4. The evidence established that Respondent was incompetent in his treatment of the eleven patients. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (d).

Unlawful prescribing

5. The evidence established that Respondent prescribed dangerous drugs without an appropriate prior examination and/or medical indication. Cause for license discipline for unprofessional conduct therefore exists pursuant to Business and Professions Code sections 2242, subdivision (a), and 2234, subdivision (a).

6. The evidence established that Respondent engaged in repeated acts of clearly excessive prescribing of controlled substances as determined by the standard of the community of physician licensees. Cause for license discipline for unprofessional conduct therefore exists pursuant to Business and Professions Code sections 725, subdivision (a), and 2234, subdivision (a).

Inadequate record-keeping

7. The evidence established that Respondent failed to maintain adequate and accurate records relating to the provision of services to his patients by failing to document a treatment plan for patients. Cause for license discipline for unprofessional conduct therefore exists pursuant to Business and Professions Code sections 2266, and 2234, subdivision (a).

Postdated prescriptions and alleged violations of the ISO

8. Complainant alleges that Respondent committed unprofessional conduct "under section 2234 and/or under 2234(e) for dishonest or corrupt acts and/or through 2238 for violations of Health and Safety Code sections 11157, 11172, and/or 11173" by "the issuing of a false and/or postdated prescription of controlled substances" and by violating the terms of the ISO, which ordered him to cease prescribing controlled substances effective April 5, 2011. The basis for the allegations are the incident described in Finding 108, where someone filled a postdated prescription for Patient KM after KM had passed away, and those described in Findings 33 and 34, where prescriptions were filled after the ISO was issued.

9. Respondent had a practice of issuing sequential prescriptions dated on the date he intended them to be valid, rather than the date he issued them; in other words, he post-dated

prescriptions. Respondent surrendered his prescription pad after the ISO was issued. It is reasonable to infer that the prescription filled after KM died was issued before he died. It is also reasonable to conclude that the small number of prescriptions that were filled after the ISO was issued were prescriptions actually issued prior to the ISO. Although the method of issuance was not legally correct, it was not demonstrated that the issuance of postdated prescriptions was dishonest, fraudulent, or amounted to a corrupt act, or that Respondent willfully violated the ISO.

10. The evidence established that Respondent postdated prescriptions for controlled substances. Cause for license discipline therefore exists pursuant to Health and Safety Code section 11172, which states that "No person shall antedate or postdate a prescription," and Business and Professions Code section 2234, subdivision (a).

Other matters

11. Business and Professions Code section 3527 provides for the denial, suspension, or revocation of the authority to supervise physician assistants of a physician who has committed unprofessional conduct or a violation of the Medical Practices Act or its corresponding regulations. Cause for such action exists by reason of the above-described violations.

ANALYSIS

12. In the introduction to his closing argument, Respondent incorrectly quoted a provision of the Medical Practice Act that addresses the prescription of drugs to patients experiencing intractable pain:

> No physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain. Business and Professions Code section 2241.5(c).

The provision is found in Business and Professions Code section 2241.5, subdivision (b), and is correctly quoted as follows:

> No physician and surgeon shall be subject to disciplinary action by the board for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

The distinction is important, because the provision goes on to state that the Board's disciplinary authority remains in tact when a physician has violated other sections of the Act, including by committing unprofessional conduct, gross negligence, repeated acts of negligence, or practicing incompetently. In other words, identifying a patient as suffering from intractable

or chronic pain does not provide a physician immunity from discipline. Patients are absolutely entitled to pain relief. They are also entitled to be treated with good, safe, care: care that is consistent with the standard of care in the medical community.

13. Cause for discipline having been established, it remains to determine the appropriate measure of discipline. In this regard, it is noted that the purpose of these proceedings is protection of the public, not punishment of the licensee. When possible, certificates should be placed on probation with conditions, such as completing educational courses, designed to enable rehabilitation and eventual reinstatement. Such a result is often appropriate the first time a physician is found in violation of the Act. In this matter, however, it is determined that the issuance of a probationary license would not be consistent with public safety.

Respondent has chosen to follow his own path based upon his own theories and regardless of the standard established by the relevant medical community. He has studied pain management and prescribing, including the various drugs available to be prescribed, and has concluded that his program not only treats intractable pain, but can cure it. On the issue of the toxicity of acetaminophen, a matter of grave concern to all of the other professionals who testified and the FDA, he is likewise convinced that his patients are unique and are not likely affected. Respondent did acknowledge violating the laws and regulations as concerns sequential prescriptions and that he learned some useful things in the two courses he took. But on the crucial matters that can mean life or death for patients in his care, he is recalcitrant.

There can be no doubt that Respondent cares about his patients in his own way. But that care is provided through a narrow lens that sees only what he chooses to see, whether about possible effects of the medications he prescribes or the behavior of his patients. Respondent argued that the establishment of trust would be prevented, and the doctor-patient relationship tainted, if he tested his patients for drugs. He evidenced a naïveté that strained credulity; trusting, as a matter of policy, almost everything told him by his patients, no matter their background or obvious pattern of behavior.

The laws surrounding the prescribing of narcotics are designed not only to protect patients, but also the general public. The public health is endangered when controlled substances are diverted for non-medical use. It is reasonable to infer, based on his prescribing practices and the facts surrounding these patients, that dangerous narcotics prescribed by Respondent were sold or otherwise distributed to non-patients. And there was scant evidence that this possibility caused Respondent any measurable amount of concern. With blinders firmly in place, he conducted his practice in accordance with his own idiosyncratic views and methods, in disregard of the safety of his patients and the public health. There is no reasonable basis upon which to find that he would change his practice to conform to the standard of care required of physicians in California. Accordingly, it is determined that the public protection requires revocation of Respondent's certificate.

ORDER

Physician's and Surgeon's Certificate No. C 17929, issued to Respondent Edward Manougian, M.D., is revoked.

DATED: August 28, 2012

MARY-MARGARET ANDERSON
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **EDWARD MANOUGIAN, M.D.** 1132 Lawrence Court El Cerrito, CA 94530-2411 Physician's and Surgeon's Certificate No. C 17929 Respondent.	Case No. 12-2007-187981 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this Second Amended Accusation ("Accusation") solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about August 16, 1956, the Medical Board of California issued Physician's and Surgeon's Certificate Number C 17929 to Edward Manougian, M.D. (Respondent). At all times relevant to the charges brought herein this license has been in full force and effect. Unless renewed, the certificate will expire on April 30, 2013.

LICENSE STATUS: INTERIM ORDER OF SUSPENSION

3. On April 5, 2011, a conditional Interim Order of Suspension was issued against Respondent by Administrative Law Judge Ruth A. Astle, Medical Quality Hearing Panel of the Office of Administrative Hearings, State of California. In said Interim Order of Suspension, it was found that, pursuant to Government Code section 11529, Respondent represents a clear and present danger to the public by his dangerous prescribing practices and that his continued prescribing will endanger the public health, safety or welfare. Respondent's physician's and surgeon's certificate was suspended but the suspension was stayed on the condition that Respondent be immediately restrained and prohibited from: possessing, prescribing, dispensing, furnishing, administering or otherwise distributing any controlled substance or any dangerous drug; possessing or holding any and all controlled substances prescription forms (triplicates) and regular prescription blanks, Drug Enforcement Administration (DEA) Drug Order Forms, and any and all DEA permits, which documents shall be surrendered by Respondent to the Medical Board for safekeeping, upon demand, pending further order in the matter. The Interim Order of Suspension remains in force and effect until a final decision on this matter is issued and adopted by the Medical Board.

JURISDICTION

4. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

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"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

6. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

7. Section 2234 of the Code states:

"The Division of Medical Quality[1] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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[1] The term "Board" means the Medical Board of California. "Division of Medical Quality" shall also be deemed to refer to the Board (Bus. & Prof. Code section 2002).

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

8. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

9. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

10. Section 2266 of the Code provides that "the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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PERTINENT DRUGS

11. **Ativan**, a trade name for **lorazepam**, is used for anxiety and sedation in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code, and a Schedule IV controlled substance as defined by Section 1308.14 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

12. **Dilaudid** is a trade name for **hydromorphone hydrochloride**. It is a Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (d) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Dilaudid is a hydrogenated ketone of morphine and is a narcotic analgesic. Its principal therapeutic use is relief of pain. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution. Patients receiving other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression. When such combined therapy is contemplated, the use of one or both agents should be reduced.

13. **Fentanyl** is an opioid analgesic. **Duragesic** is a trade name for a fentanyl transdermal system. Fentanyl is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Fentanyl's primary effects are anesthesia and sedation. Fentanyl is a strong opioid medication and is indicated only for treatment of chronic pain (such as that of malignancy) that cannot be managed by lesser means and requires continuous opioid administration. Fentanyl presents a risk of serious or life-threatening hypoventilation. When patients are receiving Fentanyl, the dosage of central nervous system

depressant drugs should be reduced at least 50%. Use of Fentanyl together with other central nervous system depressants, including alcohol, can result in increased risk to the patient.

14. **Methadone hydrochloride** is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (c) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other narcotic analgesics.

15. **Norco** is a trade name for **hydrocodone bitartrate with acetaminophen**. Hydrocodone Bitartrate is semisynthetic narcotic analgesic. It is a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e) of the Health and Safety Code, and a Schedule III controlled substance as defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

16. **OxyContin** is a trade name for **oxycodone hydrochloride** controlled-release tablets. Oxycodone is a white odorless crystalline powder derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. OxyContin is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations. OxyContin should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol.

17. **Percocet**, a trade name for a combination of **oxycodone hydrochloride and acetaminophen**, is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1)(N), of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Percocet can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Percocet contains 5 mg of oxycodone hydrochloride and 350 mg of acetaminophen. Repeated administration of Percocet may result in psychic and physical dependence.

18. **Phenergan** is a trade name for **promethazine HCI**. It is a Schedule V controlled substance under Health and Safety Code section 11058, and a Schedule V controlled substance under section 1308.15 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Phenergan has anti-histaminic, sedative, anti-motion sickness, anti-emetic, and anti-cholinergic effects. Phenergan may significantly affect the actions of other drugs. It may increase, prolong, or intensify the sedative action of central-nervous-system depressants.

19. **Phenergan (promethazine) with codeine cough syrup** is a Schedule V controlled substance under Health and Safety Code section 11058, and a Schedule V controlled substance under section 1308.15 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

20. **Roxicet** is a trade name for a combination of **oxycodone hydrochloride and acetaminophen**, a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1), of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Roxicet can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

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21. **Soma** is a trade name for **carisoprodol** tablets; carisoprodol is a muscle-relaxant and sedative. It is a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e) of the Health and Safety Code, and a Schedule III controlled substance as defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Since the effects of carisoprodol and alcohol or carisoprodol and other central nervous system depressants or psychotropic drugs may be addictive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.

22. **Valium** is a trade name for **diazepam**, a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code, and a Schedule IV controlled substance as defined by Section 1308.14 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Diazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence.

23. **Vicodin ES** is a trade name for a combination of **hydrocodone bitartrate and acetaminophen** and is a semisynthetic narcotic analgesic. It is a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e), of the Health and Safety Code, and a Schedule III controlled substance as defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Vicodin ES tablets contain 7.5 mg of hydrocodone bitartrate and 750 mg of acetaminophen. Alcohol and other CNS depressants may produce an additive CNS depression, when taken with this combination product, and should be avoided. Patients taking other narcotic analgesics, antihistamines, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with Vicodin ES may exhibit an additive CNS depression. The dose of one or both agents should therefore be reduced. Repeated administration of Vicodin ES over a course of several weeks may result in psychic and physical dependence. In patients with

severe hepatic or renal disease, effects of therapy should be monitored with serial and/or renal function tests. The total 24 hour dose of Vicodin ES should not exceed five tablets. The maximum 24 hour dosage of acetaminophen should not exceed 4000 mg. (4 grams). At high levels, acetaminophen can cause liver toxicity and even death.

24. **Xanax** is a trade name for **alprazolam** tablets. Alprazolam is a psychotropic triazolo analogue of the benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code, and a Schedule IV controlled substance as defined by Section 1308.14 (c) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax.

RESPONDENT'S PRACTICE

25. At all times relevant to this matter, respondent practiced medicine in Pinole and Castro Valley, California. Respondent was interviewed by Medical Board Senior Investigator Noelle Holloway and District Medical Consultant Martha Snider on March 30, 2010, and April 27, 2010. Respondent reported that, since August 2007, he has been engaged in a solo practice, currently in Hercules, California, specializing in chronic pain management. Respondent is not board certified. Respondent stated that he works two days per week, has no hospital privileges, and that he accepts only cash for his services. Respondent said that many of his patients are poor and do not have insurance. Respondent does not accept insurance, including Medi-Cal. Respondent reported that he charges $300 for an initial visit; $200 for a visit to get sequential prescriptions (prescriptions that include 2 refills); and, $100 for an office visit. Respondent stated that an office visit and a visit to get sequential prescriptions are treated the same and each lasts approximately 20 minutes. Respondent explained that he charges more for the visit to get sequential prescriptions because patients get three months of care for the price of two months.

Respondent stated that his patients come from all over, including from Sacramento, Modesto, and as far away as Red Bluff to see him.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. I.G.[2])

26. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) and/or 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to patient I.G. constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

27. On or about December 1, 2008, the Medical Board received a complaint about Respondent from a pharmacist who was concerned that Respondent was excessively prescribing narcotics to patient I.G.: #120 OxyContin 80 mg., #240 Norco 10/325, #180 Soma 350 mg., #120 Valium 10 mg., and 32 oz. Phenergan with codeine syrup. A CURES patient activity report for patient I.G. for the time period of 7/01/2007 through 12/11/2008 indicated that she received medications, primarily Vicodin, from eight different doctors and used two different pharmacies.

28. On September 11, 2008, patient I.G., a 61-year-old female, first saw Respondent. Patient I.G. had a history of alcohol abuse, anxiety, and depression. Respondent noted that the patient had stopped working ten years before and was on Social Security Disability Income.

29. At the September 11, 2008 visit, Patient I.G. complained of low back pain radiating down both legs, which she rated as 10/10. Respondent diagnosed that patient I.G. had lumbar radiculopathy, cervical spondylosis, foot deformity bilaterally, osteoarthritis of the knees, a right wrist problem, chronic pain syndrome, chronic bronchitis, post-peptic ulcer, and frontal headaches. There is nothing documented in Respondent's medical records that confirms he performed a full physical examination, that substantiates a specific radiculopathy, and/or that would confirm a diagnosis of cervical spondylosis. Respondent requested routine x-rays of the

[2] The patients' names are kept confidential to protect their right to privacy but will be identified to Respondent in discovery.

patient's lumbar spine, cervical spine, both knees and feet, and the right wrist and asked the patient to return in one month.

30. On September 11, 2008, Respondent rapidly increased the dosage of narcotics for patient I.G. and prescribed, without a medical indication, an unacceptably high level of sedating agents: #180 Soma 350 mg tablets at a rate of six per day, #120 Valium 10 mg tablets at a rate of four per day, and 32 oz. of Phenergan with codeine syrup, 2-3 teaspoons every 4 hours. In addition, Respondent prescribed #120 OxyContin 80 mg tablets and #240 Norco 10/325 tablets per month.

31. According to prior records in Respondent's chart, I.G. was dismissed as a pain patient by her previous physician for not following through with ordered laboratory studies or therapy. In May 2008, patient I.G. was diagnosed by a physician at Brookside Community Health Center with peptic ulcer disease, alcoholism, chronic low back pain, and with headaches possibly secondary to Vicodin use. On May 30, 2008, lab results showed that patient I.G. tested positive for opiates/hydromorphone (Dilaudid) and a benzodiazepine (Oxazepam), two substances for which she was not getting prescriptions. Prior to seeing Respondent, patient I.G. had been prescribed 30 mg. of Temazepam for sleep and #100 Hydrocodone 7.5 mg tablets per month.

32. Respondent's records include a chart note, dated September 26, 2008, from Brookside Community Health Center that I.G. was seen for general pains that have increased since her last visit and in which I.G. did not inform the physician that she was also being treated for chronic pain by Respondent.

33. On or about October 10, 2008, Respondent noted that a pharmacist expressed concern that I.G. was getting too many medications in one prescription. Respondent refilled the patient's medications: #120 OxyContin 80 mg., #180 Soma 350 mg., #240 Norco 10/325, #120 Valium 10 mg., and 32 oz. Phenergan with codeine cough syrup.

34. On October 24, 2008, Respondent noted that he reviewed patient I.G.'s prior medical records from Brookside Community Health Center. He noted, among other things: chronic low back pain, alcohol, smokes, degenerative joint disease, insomnia, depression/anxiety, chronic back pain and wrist pain, history of alcohol abuse, and sober, going to church.

35. On November 7, 2008, Respondent noted that patient I.G. said that she had x-rays done but he had not received the results. The patient reported her pain to be at worst 6/10 and at best 0/10. Respondent refilled her medications, same as on October 10, 2008.

36. On December 3, 2008, Respondent's records indicate that patient I.G. said that she had x-rays done but he still had not received the results. Respondent noted that he lectured the patient on how to take OxyContin and told her she had two strikes and has only one more strike before she will have to seek care elsewhere.

37. On January 8, 2009, Respondent noted that patient I.G. was feeling better now that she was taking OxyContin properly. She reported that her worst pain was 1 or 2/10 and that she no longer had shooting pain down her lower extremity. Respondent refilled I.G.'s prescriptions: #120 OxyContin 80 mg., #180 Soma 350 mg., #240 Norco 10/325, #120 Valium 10 mg., and 32 oz. Phenergan with codeine cough syrup.

38. On February 6, 2009, Respondent noted that patient I.G. was doing well, gaining weight, and had virtually no pain. Respondent issued sequential prescriptions for the next three months (2/06, 3/06, and 4/03).

39. On May 1, 2009, Respondent's records indicate that patient I.G. reported that she is feeling better and living a better quality of life and that her worst pain is 2/10. Respondent issued sequential prescriptions for the next three months (5/01, 5/29, and 6/26).

40. On August 12, 2009, Respondent's records indicate that patient I.G. missed an appointment and ran out of medications because of being in Michigan and having two deaths in the family. She reported that her last dose of medication was three weeks ago and that her pain was now a 7/10. Respondent issued sequential prescriptions for the next three months (8/12, 9/09, and 10/07): #120 OxyContin 80 mg., #180 Soma 350 mg., #240 Norco 10/325, #120 Valium 10 mg., and 32 oz. Phenergan with codeine cough syrup.

41. On November 4, 2009, Respondent noted that the patient was very slow in speech and having difficulty relating details. According to Respondent's records, the patient reported being under a great deal of stress, that 5 family members had died and that her daughter was ill. She told him that she "feels like checking into a mental hospital." Her worst pain was 7/10 in the low

back and shoulders and she had pain into her legs, swollen feet, headaches, and could not sleep. Respondent added Elavil to the patient's prescriptions.

42. On January 22, 2010, Respondent's records indicate he was informed that patient I.G. died alone at home and was found on the kitchen floor with soup boiling over, with no foul play suspected. Respondent, as her treating physician, completed the death certificate and listed the cause of death as a "cerebrovascular accident," a diagnosis that is unsubstantiated by the medical records.

43. Respondent's overall conduct, acts and/or omissions, with regard to patient I.G., as set forth in paragraphs 26 through 42 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or (d) and/or section 2242, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient I.G. as follows:

a. Respondent failed to obtain and document informed consent from patient I.G..

b. Respondent failed to adequately assess the patient's psychological functioning.

c. Respondent failed to conduct periodic review of the patient, such as obtaining random urine drug screens and/or a CURES patient activity report, which alone constitutes an extreme departure from the standard of care.

d. Respondent failed to consider referring this patient to another pain specialist and/or failed to consult with another pain specialist about the care of this patient.

e. Respondent diagnosed cervical spondylosis without objective findings to support the diagnosis.

f. Respondent diagnosed lumbar radiculopathy in patient I.G. without a physical examination and findings to support such a diagnosis.

g. Respondent prescribed OxyContin, Norco, Soma, Valium, and Phenergan with codeine syrup to patient I.G. without a substantiated medical diagnosis and/or medical indication to support prescribing each of these medications, which constitutes extreme departures from the standard of care for each prescription.

h. Respondent started the patient with a dose of 320 mg. a day of OxyContin, which is not a starting dose and is a potentially fatal dose, particularly when taken in combination with the other medications prescribed by Respondent: Soma, Valium, and Norco.

i. Respondent started the patient with a dose of Norco 10/325 at eight pills a day (80 mg of hydrocodone).

j. Respondent failed to tailor his pharmacological treatment to patient I.G.'s needs and, in fact, his treatment was likely detrimental to the patient. For example, Respondent stated in his interview that he thought that Phenergan with codeine would be useful for sleep and for the patient's bronchitis. It was an extreme departure from the standard of care to prescribe Phenergan with codeine syrup to patient I.G., who had chronic bronchitis.

k. Respondent failed to properly evaluate the patient when on 1/04/2009 she stated that she might want to check into a mental hospital.

l. Respondent demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology in his acts and omissions with regard to patient I.G.'s treatment, which includes, for example, but is not limited to: (1) he did not demonstrate an understanding that opiates must be started gradually and titrated upward, provided that there is first a justifiable medical reason to use them; (2) he did not demonstrate an understanding that sedating agents have an additive effect; (3) he did not demonstrate an understanding that sedating agents plus agents that suppress respiration, such as the Phenergan with codeine syrup, can result in a fatal event; (4) he did not demonstrate an understanding that prescribing high doses of sedatives (Valium and Soma) in combination with the prescribed dose of OxyContin is dangerous and can readily produce a fatal drug interaction, and (5) he prescribed Phenergan with codeine cough syrup to help the patient sleep.

m. Respondent failed to recommend a post-mortem evaluation to determine a cause of death for patient I.G., which conduct diverted attention away from his prescribing and prevented the public and I.G.'s family from knowing whether patient I.G. died as a result of the potentially fatal doses of controlled substances prescribed by Respondent.

n. Respondent failed to document a treatment plan.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. K.M.)

44. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) and/or 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to patient K.M. constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

45. According to Respondent's undated note of an initial visit, patient K.M., a 38-year-old paraplegic man, saw respondent for a complaint of stabbing, burning, and throbbing neck pain, which was attributed to a 1994 gunshot injury in which he lost feeling in his legs. According to the undated history and physical, the patient reported that he had been arrested for public drunkenness the year prior and also had been arrested for cocaine abuse, for which he served seven months of incarceration and three years of probation. He also reported that he had a primary care physician, Dr. Mahoney, and that he was getting #60 OxyContin 80 mg. and Diazepam monthly, and was using "Norco from friends" and occasional marijuana.

46. Since at least December 2006, Respondent regularly prescribed to patient K.M. excessive amounts of controlled substances for which there was no medical indication established for the medications and/or the quantities prescribed. On December 1, 2006, Respondent refilled the following prescriptions for K.M.: #240 OxyContin 80 mg., #150 Norco, and #180 Diazepam.

47. On January 22, 2007, Respondent called in a refill for patient K.M. of #150 Norco 10/325 and #60 Soma 350 mg..

48. On January 26, 2007, Respondent noted that K.M. reported his medications were stolen. Respondent prescribed #240 OxyContin 80 mg, #180 Norco 10/325, #180 Diazepam 10 mg., #180 Ativan 2 mg., and #30 Lidoderm patches.

49. On or about August 24, 2007, Respondent refilled K.M.'s medications, which included #240 Norco 10/325, #180 Soma 350 mg., #240 OxyContin 80 mg., #180 Valium 10 mg., Cialis, and Lidoderm samples. The patient was asked to return in four weeks.

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50. On September 7, 2007, Respondent's records indicate that patient K.M. was involved in a car accident and that the patient lost his medications. Respondent noted that he suspected K.M. was in an environment of drug dealers and alcoholics. Respondent's records show he prescribed #120 OxyContin 80 mg. for two weeks.

51. On October 12, 2007, Respondent refilled patient K.M.'s prescriptions including #240 OxyContin 80 mg., #300 Norco 10/325, #120 Dilaudid 8 mg., #180 Valium 10 mg., #30 Ambien 10 mg., and 32 oz. Promethazine with codeine cough syrup.

52. On November 9, 2007, Respondent's records indicate that patient K.M. claimed to be in pain since the accident because his head hit the windshield when his seatbelt failed. Respondent prescribed #240 OxyContin 80 mg., #300 Norco 10/325, #120 Dilaudid 80 mg, and #180 Valium 10 mg..

53. On December 7, 2007, Respondent noted that patient K.M. was hospitalized for three weeks because of an infection of his left upper extremity at the elbow. Respondent increased the dosages of OxyContin 80 mg to #300 pills and of Norco 10/325 to #360 pills. He also prescribed #180 Valium 10 mg., #120 Dilaudid 80 mg., and #30 Restoril 30 mg., #28 Fentora 800 mcg., and Phenergan with codeine syrup.

54. Presumably because Patient K.M. had a history of losing his medications, Respondent noted that the OxyContin 80 mg. was "lost again" and had patient K.M. sign a handwritten statement dated December 14, 2007 that he has a lock box for his medications and that he will never lose them again.

55. On January 4, 2008, Respondent noted that patient K.M. reported that the Fentora was too strong and that his mother had thrown it away. Respondent prescribed #300 OxyContin 80 mg., #360 Norco 10/325, and #180 Valium 10 mg..

56. On February 1, 2008, Respondent's records indicate that K.M. felt a lot better and that he had smoked marijuana about three hours ago. Respondent prescribed 32 oz. Phenergan with codeine cough syrup, #300 OxyContin 80 mg., #400 Norco 10/325, and #200 Soma 350 mg., which is a potentially toxic level of acetaminophen.

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57. Three weeks later, on February 22, 2008, Respondent noted that patient K.M. was doing well now that he had a safe in which to lock his medications and that the patient's worst pain was 1-2/10. Respondent prescribed 48 oz. Phenergan with codeine cough syrup, #300 OxyContin 80 mg, #400 Norco, and #200 Soma.

58. Less than three weeks later, on March 7, 2008, Respondent noted that patient K.M. had lost his prescription for Norco, Soma and Phenergan with codeine cough syrup. Respondent issued refill prescriptions for #400 Norco, #200 Soma, and 48 oz. Phenergan with codeine cough syrup.

59. Two weeks later, on March 14, 2008, Respondent again refilled patient K.M.'s prescription medications: #360 OxyContin 80 mg., #400 Norco 10/325, and 32 oz. Phenergan with codeine syrup. Respondent noted that he also gave the patient samples of a muscle relaxant. Respondent also noted he made an appointment for K.M. to see an orthopedist specialist on April 30, 2008.

60. Thirteen days later, on March 27, 2008, Respondent refilled K.M.'s medications, including #360 OxyContin 80 mg., #400 Norco 10/325, and 32 oz. Phenergan with codeine syrup.

61. Fifteen days later, on April 11, 2008, Respondent noted that K.M. failed to keep the appointment with the orthopedist. According to Respondent's records, patient K.M. apparently did not come to see Respondent but instead the patient's niece came to the office to pick up K.M.'s prescriptions. Respondent refilled K.M.'s medications, including #400 Norco 10/325, #200 Soma 350 mg, and 32 oz. Phenergan with codeine.

62. One week later, on April 18, 2008, it is unclear whether Respondent saw patient K.M. but Respondent prescribed #360 OxyContin 80 mg. and another 32 oz. Phenergan with codeine syrup. Respondent also noted that K.M.'s appointment with the orthopedist was rescheduled for 5/15/2008.

63. Three weeks later on May 9, 2008, Respondent noted that patient K.M.'s pain was at worst 10/10 and at best 0/10. Respondent refilled K.M.'s prescriptions, including #360 OxyContin 80 mg., #400 Norco 10/325, #200 Soma 350 mg., and 64 oz. Phenergan with codeine

cough syrup. Respondent asked the patient to return in 12 weeks and issued these prescriptions with recurrent refills for 6/06 and 7/04.

64. On or about July 18, 2008, Respondent's records indicate that K.M.'s niece came to the office to pick up an early prescription because K.M. ran out of his medications. Respondent prescribed an eleven-day supply: #132 OxyContin, #143 Norco, and #200 Soma.

65. On August 1, 2008, Respondent apparently saw the patient and refilled K.M.'s prescriptions, including #360 OxyContin 80 mg., #400 Norco 10/325, #300 Soma 350 mg., and 64 oz. Phenergan with codeine cough syrup. Respondent asked the patient to return in 4 weeks and issued sequential prescriptions for the #360 OxyContin for 8/29 and 9/26. Respondent also noted that "The marihuana (sic) Rx is working out well" but there is no documentation in his records of a recommendation for medical marijuana being given to the patient.

66. On September 5, 2008, Respondent noted that K.M.'s sister threw out his medications when she cleaned house for inspection by Home Health Services. Respondent refilled #360 OxyContin 80 mg..

67. On September 25, 2008, Respondent's records indicate that K.M. needed early refills of Phenergan with codeine syrup, Norco, and Soma. Respondent apparently called in refill prescriptions for four days of medications.

68. One day later, on September 26, 2008, Respondent saw K.M. and noted that he was very talkative. Respondent added #240 Methadone 10 mg tablets to patient K.M.'s treatment while also prescribing #360 OxyContin 80 mg. on that day. There is no medical indication for the prescribing of methadone.

69. On October 16, 2008, Respondent's records indicate that K.M. "ran short" of Norco. Respondent prescribed #400 Norco.

70. One week later, on October 23, 2008, Respondent noted that K.M. was taking OxyContin at a faster rate because of hemorrhoid pain. Respondent refilled K.M.'s prescriptions: #360 OxyContin 80 mg., #240 Norco 10/325, #240 Methadone 10 mg., and 64 oz. Phenergan with codeine syrup. Respondent refilled prescriptions for these same controlled substances on November 19, 2008.

71. On December 10, 2008, Respondent noted that K.M. was hospitalized two weeks for presumptive gastroenteritis and was treated with pain medications at the hospital. With no apparent consideration given to the fact that K.M.'s pain medications were provided for two weeks by the hospital, Respondent routinely refilled K.M.'s prescriptions: #360 OxyContin, #400 Norco 10/325, #240 Methadone 10 mg., and 120 oz. Phenergan with codeine syrup. Respondent noted that K.M. was to return in four weeks.

72. On January 2, 2009, Respondent noted that K.M. was a "bit spacey" but was doing better. Respondent prescribed #360 OxyContin, #240 Norco 10/325, #240 Methadone 10 mg., and 120 oz. Phenergan with codeine syrup for the month.

73. On January 28, 2009, Respondent's records indicate that K.M.'s nephew helped write a statement of how K.M. is going to take his OxyContin. Respondent noted that K.M. was high on marijuana at the visit. Respondent refilled K.M.'s prescriptions for the month.

74. On February 25, 2009, Respondent refilled K.M.'s prescriptions for the month: #360 OxyContin, #240 Norco 10/325, #240 Methadone 10 mg., and 64 oz. Phenergan with codeine syrup.

75. On February 27, 2009, March 6, 2009, and April 1, 2009, Respondent noted problems with different pharmacies and K.M.'s medications.

76. On March 20, 2009, Respondent prescribed for K.M. for the month: #360 OxyContin, #240 Methadone 10 mg., #90 Xanax 2 mg., #100 Sodium Docusate and 64 oz. Phenergan with codeine syrup.

77. On April 17, 2009, Respondent noted that K.M. has a primary care physician. Respondent refilled K.M.'s monthly prescriptions: #360 OxyContin, #240 Methadone 10 mg., and Xanax and Sodium Docusate.

78. On June 10, 2009, Respondent noted that K.M. said he stopped smoking marijuana because it "gave him bronchitis" and said that his worst pain was 0/10. Respondent refilled K.M.'s prescription medications: #360 OxyContin, #300 Methadone 10 mg., #90 Xanax, #300 Sodium Docusate 250 mg., and 80 oz. Phenergan with codeine syrup. Respondent noted that K.M. was to return in 12 weeks.

79. On September 2, 2009, Respondent noted that K.M.'s pain is controlled with his worst pain at 0/10. Respondent prescribed: #360 OxyContin, #250 Norco 10/325, #300 Methadone 10 mg., #90 Xanax, #300 Sodium Ducosate, and 80 oz. Phenergan with codeine syrup. Respondent also issued sequential prescriptions for 9/30/09 and 10/28/2009.

80. On November 27, 2009, Respondent's records indicate he was informed that patient K.M. suffered a stroke. K.M. missed his scheduled appointment with Respondent on November 25, 2009.

81. Respondent did not see, evaluate and re-assess the patient's acute change of condition but on December 9, 2009, Respondent issued prescriptions for K.M. in the same quantities of controlled substances without a medical indication: #360 OxyContin, #300 Methadone, #90 Xanax, #250 Norco, #300 Sodium Ducosate, and Phenergan with codeine syrup.

82. On February 12, 2010, Respondent's records indicate that K.M.'s mother came by three weeks early for refills of Xanax, Norco, and Phenergan with codeine syrup because K.M. lost his medications. Respondent noted that K.M. was hospitalized with a respiratory problem and given antibiotics.

83. Respondent saw patient K.M. on March 3, 2010 and noted that the stroke affected K.M.'s whole right side. Respondent did not document an examination of the patient and, without any objective data to establish a medical indication, he prescribed #360 OxyContin, #300 Methadone, #120 Xanax 2 mg, #300 Norco, and 80 oz of Phenergan with codeine syrup. Moreover, Respondent gave the patient sequential prescriptions for 3/31/2010 and 4/28/2010.

84. Patient K.M. died on March 20, 2010. An autopsy was performed on patient K.M. and the cause of death was listed as "polypharmacy," with toxic levels of alprazolam (Xanax) and of Methadone found in the patient. Notably, no OxyContin was found in the patient's system.

85. Respondent's overall conduct, acts and/or omissions, with regard to patient K.M., as set forth in paragraphs 44 through 84 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and medical indication, pursuant to Business and Professions Code sections 2234 subdivisions (b)

and/or (d) and/or 2242, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient K.M. as follows:

a. Respondent failed to obtain and document informed consent from patient K.M..

b. Respondent failed to perform an adequate history and physical examination and failed to adequately assess the patient's psychological functioning.

c. Respondent failed to conduct periodic review of the patient, such as obtaining random urine drug screens and/or a CURES patient activity report, which alone constitutes an extreme departure from the standard of care.

d. Respondent failed to recognize that K.M. likely had a psychiatric disorder, which meant that he should not be treated by a solo practitioner and probably should not be treated with controlled substances.

e. Respondent failed to consider referring this patient to another pain specialist and/or failed to consult with another pain specialist about the care of this patient.

f. Respondent failed to tailor his pharmacological treatment to K.M.'s medical needs and prescribed controlled substances to patient K.M. without a substantiated medical diagnosis and/or medical indication to support prescribing each of these medications, which constitutes extreme departures from the standard of care for each prescription.

g. Respondent prescribed more than 80 mg daily of Methadone to K.M. which can be a toxic dose, and which alone constitutes an extreme departure from the standard of care.

h. Respondent increased the amount of OxyContin from 60 to 240 tablets without a documented medical reason or finding.

i. Respondent demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology in his acts and omissions with regard to patient K.M.'s treatment, which includes, for example, but is not limited to: (1) he did not demonstrate an understanding that he was prescribing toxic and potentially fatal doses of controlled substances, (2) he routinely issued early refills of narcotic medications, (3) he did not demonstrate an understanding that the patient had a substance abuse problem and that the patient was probably diverting the OxyContin, (4) he failed to exercise any medical decision-making and failed to

obtain objective data to assess the patient's current condition before continuing to prescribe excessive quantities of controlled substances, and (5) he prescribed Phenergan with codeine cough syrup to help the patient sleep.

j. Respondent failed to document a treatment plan.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. J.D.)

86. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) and/or 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to patient J.D. constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

87. On or about October 22, 2008, patient J.D., a 35-year-old female, first saw Respondent for "chronic pain management" and presented with complaints of knee pain, thigh pain, migraine, and flank pain ascribed to pancreatitis. The patient had a history of alcohol abuse, had run away from home and was sent to juvenile hall when she was fifteen. Two of her children, ages ten and fourteen, were in foster care and the oldest child who was fifteen and deaf was in a group home. The patient reported that the current medications she took included #20-30 Vicodin ES obtained from hospital emergency room visits, #24 Norco, 25 mcg. daily of Synthroid, sodium citrate, Prilosec, magnesium. Respondent diagnosed patient J.D. with musculoskeletal pain secondary to renal tubular acidosis (RTA), which is a kidney disease, without any objective findings to confirm the diagnosis. Respondent prescribed large quantities of narcotic pain medications to J.D. : #60 OxyContin 80 mg., #240 Norco 10/325, #180 Soma 350 mg., #120 Valium 10 mg., #90 Phenergan 25 and 16 oz. of Phenergan with codeine syrup.

88. Less than two weeks later, on November 4, 2008, Respondent noted that patient J.D. was hospitalized and lost her Norco there. Respondent prescribed #120 Norco 10/325 with three refills.

89. On November 19, 2008, Respondent's records indicate that patient J.D. reported her worst pain as 9/10 but there's no documentation as to the location and type of pain. It is noted that

J.D. said she was unable to get OxyContin, that she can tolerate Dilaudid but not Morphine, and that she was able to work part-time because of the Norco. Without any documented medical indication, Respondent prescribed for patient J.D.: #300 Norco 10/325, #200 Soma 350 mg., #120 Valium 10 mg., and 16 oz. of Phenergan with codeine syrup. Respondent also added prescriptions for #90 Phenergan 25 mg tablets, #10 Fentanyl 100 mc. patches, #120 Methadone 10 mg. tablets, and #30 Ativan 1 mg.

90. On December 4, 2008, Respondent noted that the patient J.D. called and said that she lost half of her Norco. Respondent called in a prescription for an additional #100 Norco.

91. On December 17, 2008, Respondent noted that J.D. said that the Fentanyl patches were helping a lot and that her worst pain was 2 or 3/10. Respondent discontinued the Methadone but continued to prescribe #10 Fentanyl 100 mcg. patches along with #300 Norco, #200 Soma, #120 Valium, #30 Ativan, #90 Phenergan 25 mg., and 16 oz. Phenergan with codeine cough syrup. Even in a narcotic-tolerant patient such as J.D., this is a potentially toxic combination.

92. On January 14, 2009, Respondent issued two separate prescriptions to J.D., one for Norco and Vicodin ES and one for Fentanyl, Soma, Valium, Ativan, and Phenergan with codeine syrup. The patient was to return in four weeks.

93. Patient J.D. died on January 23, 2009. The autopsy report dated January 27, 2009 listed the cause of death as Fentanyl toxicity.

94. Respondent's overall conduct, acts and/or omissions, with regard to patient J.D., as set forth in paragraphs 86 through 93 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without a prior examination and medical indication, pursuant to Business and Professions Code sections 2234 subdivisions (b) and/or (d) and/or 2242, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient J.D. as follows:

a. Respondent failed to obtain and document informed consent from patient J.D.

b. Respondent failed to conduct an adequate history and physical examination, failed to adequately assess the patient's psychological functioning, and failed to recognize that the

patient may have had a personality disorder that would mean that she should not be treated with controlled substances by a solo practitioner.

c. Respondent failed to conduct periodic review of the patient, such as obtaining random urine drug screens and/or a CURES patient activity report, which alone constitutes an extreme departure from the standard of care.

d. Respondent failed to consider referring this patient to another pain specialist and/or failed to consult with another pain specialist about the care of this patient.

e. Respondent prescribed Soma, Valium, and Phenergan with codeine syrup to patient J.D. without a substantiated medical diagnosis and/or medical indication to support prescribing each of these medications, which constitutes extreme departures from the standard of care for each prescription.

f. Respondent prescribed excessive doses of OxyContin and Norco to patient J.D.

g. Respondent failed to tailor his pharmacological treatment to patient J.D.'s needs and, in fact, his treatment was likely detrimental to the patient. The amount of acetaminophen prescribed to patient J.D. by Respondent at the 11/04/2008 visit is at the high threshold dosage between safe and toxic. There is no indication in the records that Respondent warned patient J.D. of the hazard of taking an over-the counter-medication containing acetaminophen, which would move her deep into the toxic range and be potentially fatal, causing liver failure.

h. Respondent demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology in his acts and omissions with regard to patient J.D.'s treatment, which includes, for example, but is not limited to: (1) he failed to recognize that he prescribed an inherently dangerous and potentially fatal combination of sedatives; (2) he did not demonstrate an understanding that sedating agents have an additive effect; (3) he did not demonstrate an understanding that sedating agents plus agents that suppress respiration, such as the Phenergan with codeine syrup, can result in a fatal event; and (4) he prescribed Phenergan with codeine cough syrup to help the patient sleep.

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i. Respondent diagnosed musculoskeletal pain secondary to renal tubular acidosis which is not supported by a physical examination and objective findings and then prescribed narcotic medications to treat his unconfirmed diagnosis of RTA.

j. Respondent failed to document a treatment plan.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. W.R.)

95. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) and/or 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to patient W.R. constitutes gross negligence and/or incompetence and/or prescribing without a prior examination and a medical indication, as more fully described herein below.

96. On or about July 12, 2008, patient W.R., a 58-year-old female, first saw Respondent with complaints of pain in her right knee and lower back. Patient W.R. had a primary care physician and reported that she had been previously diagnosed with arthritis in her back and with anxiety. W.R. was currently taking Valium and Soma from her primary care physician.

97. On or about July 31, 2008, Respondent obtained a history and physical of W.R. in which he noted that W.R. had a prior history of a gunshot wound to the head. No clear drug abuse history was obtained. Alcohol was denied. The patient reported that her right knee gave her constant pain that, at its worst was 10/10 and at best was 2/10. Respondent diagnosed W.R. with osteoarthritis of the knee and lumbar spondylosis. Respondent prescribed 32 oz. of Phenergan with codeine syrup, #240 Norco 10/325, #120 Valium 10 mg., and #120 Soma 350 mg..

98. Respondent obtained prior treating records that showed patient W.R. in May 2005 presented with very nonspecific and vague pain complaints and that in September 2007, patient W.R. was diagnosed as having significant anxiety. An MRI reading on July 14, 2008 showed that patient W.R.'s right knee had a complex tear of the posterior horn of the medial meniscus and mild to moderate osteoarthritis of the medial, lateral and patella-femoral compartments.

99. On August 29, 2008, Respondent noted that patient W.R. can sleep better with Phenergan with codeine syrup. Respondent refilled W.R.'s medications for four weeks: 32 oz.

Phenergan with codeine cough syrup, #240 Norco 10/325, #140 Valium 10 mg., #150 Soma 350 mg., and added #60 OxyContin 80 mg.

100. Respondent had in his records for patient W.R. an Operative Report dated September 24, 2008 by surgeon Joseph Matan, M.D., that documents an arthroscopic medial meniscectomy of the right knee and notes osteoarthritis.

101. On September 26, 2008, Respondent saw patient W.R., two days after her arthroscopic surgery, and noted that the patient was using a crutch and that her pain was 10/10. Respondent prescribed #120 OxyContin 80 mg., #240 Norco 10/325, #140 Valium 10 mg., #150 Soma 350 mg., 32 oz. of Phenergan with codeine cough syrup, and #100 Elavil 25 mg. with the patient to return in four weeks.

102. On October 24, 2008, Respondent's records indicate that, one month post-op, patient W.R.'s right knee was very painful, swollen and tender and that she was unable to flex or bend the knee. Respondent prescribed #60 OxyContin 80 mg., #240 Norco 10/325, #140 Valium 10 mg., #150 Soma 350 mg, and #100 Elavil 25 mg., 32 oz. Phenergan with codeine cough syrup and #50 Tylenol No. 4. The patient was to return in four weeks.

103. On November 21, 2008, Respondent's records are unclear as to whether he saw patient W.R., no physical examination is documented. Respondent increased the prescription of OxyContin to #120 and prescribed Lidoderm.

104. On December 17, 2008, Respondent noted that patient W.R. went to the E.R. yesterday because she fell while going down the stairs and both knees, hips and her low back hurt. She was "given a shot." Respondent refilled the patient's prescriptions. The patient was to return in four weeks.

105. On January 16, 2009, Respondent noted that patient W.R. had a breakdown and was in the hospital. Respondent also noted that the patient's brother is a police officer and is controlling her medications. Respondent also noted that patient W.R. cannot read or write.

106. On February 13, 2009, Respondent noted that patient W.R. was unable "to relate history even day by day" and has been given a caretaker paid by the County. He refilled the patient's medications same as on January 16, 2009 plus 3 additional refills.

107. On February 18, 2009, Respondent's records indicate problems with W.R.'s insurance and the prescription for OxyContin. Respondent noted that he told the insurer he did not give the patient methadone because it is a short-acting agent and the patient needs a long-acting opioid. Respondent charged $50 cash to make the call to the insurance company. Respondent did not see W.R. but W.R.'s daughter was present and he gave her a prescription for W.R. for #120 MS Contin 100 mg..

108. On May 8, 2009, Respondent documented that patient W.R. was able to do more activities and that she has a housekeeper. Respondent refilled her medications same as on January 16, 2009 but discontinued Tylenol No. 4 and added #100 Vicodin ES. Respondent issued sequential prescriptions for 6/05 and 7/03 with the patient to return on July 31, 2009.

109. On July 31, 2009, Respondent noted that W.R. was to have arthroscopic surgery on August 10. Respondent refilled patient W.R.'s medications: #240 Norco, #140 Valium, #120 OxyContin, #90 Elavil, 32 oz. Phenergan with codeine cough syrup. Respondent issued sequential prescriptions for 8/28 and 9/25 with the patient to return on October 23, 2009.

110. Respondent's overall conduct, acts and/or omissions, with regard to patient W.R., as set forth in paragraphs 95 through 109 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and medical indication, pursuant to Business and Professions Code sections 2234 subdivisions (b) and/or (d) and/or 2242, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient W.R. as follows:

a. Respondent failed to obtain and document informed consent from patient W.R.

b. Respondent failed to conduct an adequate history and physical examination and failed to adequately assess the patient's psychological functioning.

c. Respondent failed to conduct periodic review of the patient, such as obtaining random urine drug screens and/or a CURES patient activity report, which alone constitutes an extreme departure from the standard of care.

d. Respondent failed to consider referring this patient to another pain specialist and/or failed to consult with another pain specialist about the care of this patient.

e. Respondent prescribed Soma, Valium, and Phenergan with codeine syrup to patient W.R. without a substantiated medical diagnosis and/or medical indication to support prescribing each of these medications, which constitutes extreme departures from the standard of care for each prescription.

f. Respondent prescribed excessive doses of OxyContin to patient W.R.

g. Respondent failed to tailor his pharmacological treatment to patient W.R.'s needs and, in fact, his treatment was likely detrimental to the patient. Respondent diagnosed osteoarthritis of the knees without prescribing an anti-inflammatory medication.

h. Respondent demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology in his acts and omissions with regard to patient W.R.'s treatment, which includes, for example, but is not limited to his prescribing of Phenergan with codeine cough syrup to help the patient sleep.

i. Respondent failed to document a treatment plan.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. J.S.)

111. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) and/or 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to patient J.S. constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

112. On June 2, 2006, patient J.S., a 55-year-old female, saw Respondent with a complaint of low back pain radiating to the right calf. Respondent noted that the patient had been sharing medications with her grandmother. The patient reported her pain level in her low back at worst as 10/10 and at best 8/10. The patient worked as a drug and alcohol recovery counselor and denied drug abuse history while admitting to drinking alcohol only two times a year. Respondent documented that the patient showed a limited range of motion. Respondent reported a healing fracture of the right knee patella but the physical exam does not support this diagnosis. Respondent diagnosed cervical and lumbar radiculopathy. Respondent also documented: trigger

finger, migraine headaches, chronic pain syndrome with depression, asthma, status post hysterectomy, and presbyopia. Respondent prescribed #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma 350 mg., #120 Xanax 2 mg., and 16 oz. Phenergan with codeine syrup, which is an excessive and toxic dose of acetaminophen.

113. On July 7, 2006, Respondent saw patient J.S. at Advanced Pain Management. J.S. reported that her worst pain was 10/10 and her best pain was 7/10. She said that the medications were better than anything she had ever had. She said that she mailed the MRI reports to Respondent but they were not received. The patient promised to bring her MRI reports with her on the next visit. The patient never provided her MRI results to Respondent. Respondent prescribed: 8 oz. Phenergan with codeine syrup, #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma 350 mg., #120 Xanax 2 mg., and Lidoderm patches. Respondent had a handwritten note in the chart that appears to be a calculation that the patient is taking 7.8 grams a day of acetaminophen, which is a toxic dose.

114. On August 4, 2006, Respondent saw patient J.S. at Advanced Pain Management and Rehab Medical Group for pain from neck to right shoulder and low back pain to right lower extremity to outer calf. The patient reported her pain at worst was 10/10 and at best was 7/10. No physical examination is documented. Respondent prescribed: 16 oz. Phenergan with codeine cough syrup, #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma, #120 Xanax 2 mg., and Lidoderm samples, which is again an excessive and toxic dose of acetaminophen.

115. On September 1, 2006, Respondent documented that the patient reports that her worst pain is 10/10 in her low back. Respondent ordered an MRI of the cervical and lumbar spine. Respondent's records indicate a limited examination was done showing tenderness over the lumbo-sacral spine with exaggerated curvature. Respondent prescribed a formula of #180 Tylenol No. 4 with codeine and #240 Vicodin ES along with #180 Soma, #120 Xanax, and lactulose as well as Imitrex and Lidoderm.

116. On October 27, 2006, Respondent saw patient J.S. at the Advanced Pain Management and Rehab Medical Group. The patient did not have the MRI done. She said that she was awaiting insurance coverage. The patient complained of pain in her radicular right lower and

upper extremities. Respondent noted that the physical examination is unchanged but did not further elaborate. Respondent prescribed 16 oz. Phenergan with codeine times two, #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma 350 mg, and lactulose, which is an excessive and toxic dose of acetaminophen.

117. On December 22, 2006, Respondent's chart notes indicate that patient J.S. complained of radicular pain in her right arm and right lower extremity, of migraine headaches, and of pain in the neck, low back, elbows and hips. No physical examination is documented. The records note that the patient is awaiting insurance. Respondent prescribed 32 oz. Phenergan with codeine cough syrup, #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma, #120 Xanax, lactulose, and Imitrex.

118. On February 9, 2007, Respondent diagnosed patient J.S. with cervical radiculopathy. There is no objective physical examination documented and there is therefore no support for a diagnosis of cervical radiculopathy or of lumbar radiculopathy. Respondent prescribed 32 oz. Phenergan with codeine cough syrup, #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma, #120 Xanax 2 mg., and Imitrex and lactulose. The chart note is signed by both Respondent and Dr. Punjabi.

119. On March 30, 2007, Respondent saw patient J.S. for cervical and lumbar radiculopathy. Respondent prescribed #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma, #120 Xanax, and 32 oz. Phenergan with codeine cough syrup.

120. On May 27, 2007, Respondent's records note that patient J.S. reported no change in her condition. Respondent prescribed #240 Percocet 7.5/500, #180 Tylenol No. 4, #180 Soma, #120 Xanax, #90 Valium, and Imitrex and lactulose, which is a toxic dose of acetaminophen.

121. On June 29, 2007, Respondent's records indicate that patient J.S.'s worst pain was 10/10 and her best pain was 5/10. The patient reported that she can do some housework. She went to the emergency room for a migraine and was given a shot of Phenergan and morphine sulfate. The patient said that the Phenergan syrup helps with sleep. Respondent prescribed #240 Vicodin ES, #180 Tylenol No. 4, #180 Soma, #120 Xanax, 32 oz. Phenergan with codeine syrup, and #90 Valium.

122. On August 17, 2007, Respondent's records note that patient J.S. reported that the medications were working well and that she was functioning satisfactorily. Respondent documented lumbar radiculopathy of right lower extremity, bilateral knee osteoarthritis, and stable program in management. Respondent asked the patient to return in twelve weeks. Respondent prescribed 32 oz. Phenergan with codeine syrup times two with two refills, #240 Vicodin ES with two refills, #180 Tylenol No. 4 with two refills, #180 Soma with three refills, and #120 Xanax 2 mg. with three refills. This is an excessive and toxic dose of acetaminophen.

123. On September 14, 2007, Respondent refilled patient J.S.'s medications as follows: prescribed 32 oz. Phenergan with codeine syrup times two with two refills, #240 Vicodin ES with two refills, #180 Tylenol No. 4 with two refills, #180 Soma with two refills, and #120 Xanax 2 mg. with two refills. This is a toxic dose of acetaminophen. The patient was to return in twelve weeks.

124. On November 16, 2007, Respondent's records indicate that patient J.S. reported that her pain level was 7/10 at worst and 4/10 at best. The patient still complained of pain in her low back to the right lower extremity. Respondent refilled her medications and issued two sequential refill prescriptions. This is a toxic dose of acetaminophen.

125. On January 4, 2008, Respondent's records indicate that patient J.S.'s worst pain is 8/10 and best is 3/10, with the pain usually at 5-6/10. Respondent reviewed the patient's activities but no objective findings are documented. Respondent refilled the patient's medications plus sequential prescriptions for two months. This is a toxic dose of acetaminophen. The patient was to return on March 28, 2008.

126. On March 28, 2008, Respondent noted that patient J.S. "wants more pain relief." With no documented physical examination or any objective findings, Respondent prescribed #120 OxyContin, 32 oz. Phenergan with codeine cough syrup, #180 Tylenol No. 4, #240 Vicodin ES and #90 Flexeril.

127. On April 25, 2008, Respondent's records indicate that J.S. slipped and fell in Wal-Mart, has a fractured patella, and is to see an orthopedist soon. Respondent prescribed #120

OxyContin 80 mg., #180 Tylenol No. 4,, #240 Vicodin ES, 32 oz. Phenergan with codeine cough syrup, #90 Xanax 2 mg., and #90 Flexeril 10 mg. This is a toxic dose of acetaminophen.

128. On July 3, 2008, Respondent's records note that patient J.S. is doing well and reports her pain from 8/10 to 3/10. Respondent gave the patient recurrent refills but changed the Flexeril to #180 Soma 350 mg. In addition to the Soma, Respondent renewed the patient's prescriptions and issued sequential prescriptions for two additional months.

129. On September 26, 2008, Respondent's records noted that the patient is doing well and that she can do housekeeping, cooking and shopping. Respondent issued sequential prescriptions.

130. According to CURES patient activity reports for patient J.S., Respondent was also prescribing the following medications to patient J.S. in addition to the prescription medications documented in his records: Hydrocodone, OxyContin, and Alprazolam.

131. On December 10, 2008, Respondent noted that patient J.S. is doing well and that she reported that her pain is between 3/10 and 0/10 and that she is able to do anything that she wants. Respondent issued renewed prescriptions and sequential prescriptions for 1/07/2009 and 2/04/2009.

132. On January 2, 2009, Respondent's record notes that patient J.S. said that she lost her prescription of 9/26/2008. Respondent issued refills times two.

133. On March 4, 2009, Respondent's records indicate that patient J.S. complained of back pain and bilateral radiculopathy. The patient reported that her pain at worst is 2/10 and at best 0/10. The patient said that she is able to do much more than what she did a year ago and can do anything that she wants to do. Respondent renewed J.S.'s prescriptions: #180 Soma, #180 Tylenol No. 4, #240 Vicodin ES, #90 Xanax 2 mg., #120 OxyContin 80 mg., and 32 oz. Phenergan with codeine cough syrup. Respondent issued sequential refills for 4/01 and 4/29 with the patient to return on May 27, 2009. This is a toxic regimen of acetaminophen.

134. On May 27, 2009, Respondent noted that patient J.S. reported feeling much better and that her pain level is between 2/10 and 0/10. The patient reported that the low back pain radiating to her right knee is happening less often. Respondent refilled the patient's medications for three months and J.S. was to return on August 19, 2009.

135. In patient J.S.'s chart is a Controlled Substances Follow-Up form dated June 5, 2009 that Respondent completed for Anthem Blue Cross in which he represented that he is a pain specialist.

136. On July 31, 2009, Respondent saw patient J.S. who reported that she is doing well and that her pain is between 1/10 and 0/10. The patient indicated that she would like to go to Kansas for an indefinite time. Respondent refilled the patient's prescriptions and issued sequential prescriptions for 8/19/09, 9/16/09 and 10/14/09 with the patient to return on November 11, 2009.

137. On November 4, 2009, Respondent's records indicate that patient J.S. ran out of Vicodin ES, Tylenol No. 4 and Soma. She reported that she has low back pain radiating to her right lower extremity and that her pain is between 1-2 /10 and 8-9/10. The patient stated that methadone and morphine have made her ill. Respondent refilled her medications, which is a toxic dose of acetaminophen.

138. On January 27, 2010, Respondent's records indicate that patient J.S. went to Kansas, became ill with respiratory illness, and was hospitalized four days. Patient J.S. was placed on Prednisone, was on O2 at home, and her diabetes went out of control. This is the first mention of J.S. having diabetes in Respondent's records. Respondent refilled her prescriptions #180 OxyContin, #180 Soma, #180 Tylenol No. 4, Vicodin ES, Xanax, 48 oz. Phenergan with codeine syrup.

139. On February 24, 2010, Respondent's records indicate that the patient's pain is between 1/10 and 0/10 and that she is doing well. The patient stated that she had been told that she has pulmonary fibrosis and is on O2 at home. Respondent prescribed #180 OxyContin, #180 Soma, #180 Tylenol No. 4, #240 Vicodin ES, #90 Xanax, and 48 oz. Phenergan with codeine syrup. This is a toxic dose of acetaminophen. Respondent issued sequential prescriptions for two additional months, 3/24 and 4/21, with the patient to return on May 19, 2010.

140. Respondent's records indicate that, on an illegible date, he increased patient J.S.'s OxyContin to #120 80 mg. while also prescribing #180 Tylenol No. 4 and #240 Vicodin ES, and Phenergan with codeine syrup. This is a toxic dose of acetaminophen.

141. Respondent's records indicate that, on an illegible date, patient J.S. was satisfied with the current program. Respondent issued sequential prescriptions for #120 OxyContin 80 mg., #180 Tylenol No. 4, #240 Vicodin ES, #90 Xanax 2 mg., #90 Flexeril 10 mg., and 32 oz. of Phenergan with codeine syrup. This is a toxic dose of acetaminophen.

142. Respondent's overall conduct, acts and/or omissions, with regard to patient J.S., as set forth in paragraphs 111 through 141 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and medical indication, pursuant to Business and Professions Code sections 2234 subdivisions (b) and/or (d) and/or 2242, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient J.S. as follows:

a. Respondent failed to obtain and document informed consent from patient J.S.

b. Respondent failed to conduct an adequate history and physical examination, failed to adequately assess the patient's psychological functioning.

c. Respondent failed to conduct periodic review of the patient, such as obtaining random urine drug screens and/or a CURES patient activity report, which alone constitutes an extreme departure from the standard of care.

d. Respondent failed to refer this patient to an orthopedic specialist.

e. Respondent diagnosed cervical and lumbar radiculopathy and a healing fracture of the right knee patella without a documented physical examination and objective findings to support these diagnoses.

f. Respondent prescribed Soma, Xanax, and Phenergan with codeine syrup to patient J.S. without a substantiated medical diagnosis and/or medical indication to support prescribing each of these medications, which constitutes extreme departures from the standard of care for each prescription.

g. Respondent failed to tailor his pharmacological treatment to patient J.D.'s needs and, in fact, his treatment was likely detrimental to the patient. The amount of acetaminophen prescribed to patient J.S. was above the maximum acceptable daily dose. There is no indication in the records that Respondent warned patient J.S. of the hazard of taking an over-

the counter-medication containing acetaminophen, which would move her deep into the toxic range and be potentially fatal, causing liver failure.

h. Respondent demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology in his acts and omissions with regard to patient J.S.'s treatment, which includes, for example, but is not limited to: (1) he consistently prescribed a toxic dose of acetaminophen, more than 4 grams daily, between June 2, 2006 and through February 24, 2010, and (2) he prescribed Phenergan with codeine cough syrup to help the patient sleep,

i. Respondent failed to document a treatment plan.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. R.B.)

143. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) and/or 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to patient R.B. constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

144. On August 24, 2007, Respondent saw patient R.B., a 59-year-old male, whose chief complaint was of low back pain radiating down both legs, which the patient said developed and persisted after carrying a sofa. The patient reported using over-the counter pain medications. Patient R.B. had no primary care physician and denied getting medications from other doctors. He said that he occasionally got medications from his friends. The patient reported that Vicodin ES, Soma, Xanax, and Promethazine with codeine helped him but that Vicodin and Soma were not satisfying. Respondent's impression was lumbar degenerative disc disease and he ordered lumbar spine x-rays. Respondent prescribed for patient R.B. #140 Vicodin ES, #60 Soma 350 mg., #60 Xanax 2 mg., and 16 oz. Promethazine with codeine cough syrup.

145. On September 14, 2007, Respondent saw patient R.B. who indicated that his pain at best was 1-2/10 and at worst was 8/10. The pain worsened with activities but he could lift as much as 25-30 pounds. The patient was satisfied with his current medications. Respondent

refilled patient R.B.'s prescriptions: #140 Vicodin ES, #90 Soma 350 mg., #60 Xanax 2 mg., 16 oz. Phenergan with codeine cough syrup.

146. On December 7, 2007, Respondent's records indicate that patient R.B. complained of low back pain radiating down his left lower extremity to the knee and said that he "had to take more meds than prescribed." Respondent noted that patient R.B. lied about his identity and about having a daughter to obtain meds, which led to his prior physician refusing to treat him. Respondent prescribed for patient R.B., an increased amount of Vicodin ES to #240, plus #120 Valium 10 mg., #120 Soma 350 mg., #120 Tylenol No. 4, and 32 oz. Phenergan with codeine syrup. Respondent also issued two sequential refills and the patient was to return in 12 weeks.

147. On March 7, 2008, Respondent's records indicate that patient R. B. was seen for a visit and that the patient had significant pain, at worst 9-10/10 and at best 3-4/10. Respondent noted that x-ray results showed spondylolisthesis at L5-S1. Respondent prescribed: #120 OxyContin 80 mg., #120 Vicodin ES, #120 Soma 350 mg, 32 oz. Phenergan with codeine, and #30 Nexium 40 mg.. The patient was to return in four weeks.

148. On April 4, 2008, Respondent noted that patient R.B. reported taking his OxyContin haphazardly one at a time, "if I can believe his story." Respondent documented that he instructed the patient to take two OxyContin "po q twelve hours." Respondent also prescribed Tylenol No. 4 in an unknown quantity.

149. On May 9, 2008, Respondent's records indicate that patient R.B. says that he is exercising but can not do much more that he did a year ago. Respondent prescribed: #120 OxyContin 80 mg., #240 Vicodin ES, #120 Soma 350 mg, 32 oz. Phenergan with codeine cough syrup, and #120 Tylenol No. 4. This is a toxic dose level of acetaminophen.

150. On June 6, 2008, Respondent's records indicate that the patient's left knee is a problem and that he is scheduled for arthroscopic surgery on June 27 with an orthopedic surgeon. The patient reported that the pain in his low back was between 8-9/10 and 0/10. Respondent issued sequential prescriptions for 6/06 and 7/04/2008.

151. On August 1, 2008, Respondent's records indicate that the patient reported having arthroscopic surgery of his left knee and that he can walk better now. The patient reported that he

was doing better with the OxyContin, taking it twice daily. Respondent issued sequential prescriptions for 8/01, 8/29, and 9/26/2008.

152. On October 24, 2008, Respondent noted that patient R.B. is taking OxyContin properly and is moving well. Respondent refilled his medications and issued sequential prescriptions for 10/24, 11/21, and 12/19/2008 without specifying in his charts the types and quantities prescribed.

153. On January 16, 2009, Respondent noted that patient R.B. was taking OxyContin as he should. The patient would like Norco instead of Vicodin ES. Respondent refilled and issued sequential prescriptions for 1/16, 2/13, and 3/13/2009 with the patient to return on 4/10/2009.

154. On February 2, 2009, Respondent's records have a note apparently addressed to an insurer that indicates that patient R.B. has chronic pain syndrome as a result of lumbar spondylolisthesis of L5 and S1 and therefore requires long-acting opiates. Respondent, however, documented no objective findings that established that the spondylolisthesis was the pain generator.

155. On April 10, 2009, Respondent's records indicate that patient R. B. was not doing well and reported that the Fentanyl patch was causing nausea, dizziness, and ill feeling. Respondent's records do not document that he prescribed Fentanyl prior to this date. Respondent did not document in his chart that he issued any prescriptions on this date.

156. On July 3, 2009, Respondent's records indicate that patient R.B. is moving around "good." Respondent prescribed: #120 OxyContin, #240 Norco, #120 Soma, #120 Tylenol No. 4, and 32 oz. Phenergan with codeine cough syrup. This is a toxic level of acetaminophen.

157. On September 25, 2009, Respondent's records indicate that patient R.B.'s worst pain was 7/10 and at best was 0/10. Respondent refilled and issued sequential prescriptions for 9/25, 10/23, and 11/20/2009 and increased the amounts, prescribing: #180 OxyContin, #300 Norco, #180 Soma, #120 Methadone.

158. On December 18, 2009, Respondent's records indicate that patient R.B. reported that the methadone made him sleepy and that he would like to try a nerve pain medicine instead.

Respondent refilled the prescriptions as follows: #180 OxyContin, #300 Norco, #180 Soma, 48 oz. Phenergan with codeine syrup, and Elavil 50 mg..

159. Respondent's overall conduct, acts and/or omissions, with regard to patient R.B., as set forth in paragraphs 143 through 158 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and medical indication, pursuant to Business and Professions Code sections 2234 subdivisions (b) and/or (d) and/or 2242, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient R.B. as follows:

a. Respondent failed to obtain and document informed consent from patient R.B.

b. Respondent failed to conduct an adequate history and physical examination, particularly with regard to past alcohol and drug abuse, and failed to adequately assess the patient's psychological functioning.

c. Respondent failed to conduct periodic review of the patient, such as obtaining random urine drug screens and/or a CURES patient activity report, which alone constitutes an extreme departure from the standard of care.

d. Respondent failed to refer this patient to an orthopedic specialist.

e. Respondent's diagnosis, assessment and management of spondylolisthesis without a documented physical examination and objective findings to support the diagnosis constitutes, by itself, an extreme departure from the standard of care.

f. Respondent prescribed Soma, Xanax, and Phenergan with codeine syrup to patient R.B. without a substantiated medical diagnosis and/or medical indication to support prescribing each of these medications, which constitutes extreme departures from the standard of care for each prescription.

g. Respondent failed to tailor his pharmacological treatment to treat the diagnosis of lumbar degenerative disease and simple chronic back pain. Said treatment was likely detrimental to the patient. The amount of acetaminophen prescribed to patient R.B. was above the maximum acceptable daily dose. There is no indication in the records that Respondent warned patient R.B. of the hazard of taking an over-the counter-medication containing

acetaminophen, which would move her deep into the toxic range and be potentially fatal, causing liver failure.

h. Respondent demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology in his acts and omissions with regard to patient R.B.'s treatment, which includes, for example, but is not limited to: (1) he failed to recognize that he prescribed a toxic and inherently dangerous level of acetaminophen by consistently prescribing a toxic dose of acetaminophen, more than 4 grams daily, between May 9, 2008 and through July 3, 2009, (2) he did not demonstrate an understanding of neuropathic pain medications on 12/18/2009, (3) he prescribed Phenergan with codeine cough syrup to help the patient sleep, (4) he called in early refills and even increased the amounts of the medication without any medical indication, and (5) on 3/07/2008 he rapidly escalated the amount of OxyContin and prescribed Nexium without a medical indication.

i. Respondent failed to document a treatment plan.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. L.R.)

160. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) and/or 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to patient L.R. constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

161. On November 23, 2007, Respondent saw patient L.R., a 40-year-old female, who complained of pain in both knees. Patient L.R. was 5 feet 3 inches tall and weighed 230 pounds. Patient ascribed her knee pain to a motor vehicle accident five years earlier and said that she declined to have surgery. She stated that she had been buying medications from the street for the last two years. Respondent noted that the patient reported that she was a chronic smoker but had never abused drugs. The patient reported that her husband was on drugs and was in prison for assault and battery, he fractured the patient's jaw three years ago. Respondent also noted that the

patient was in special education classes and that she had difficulty understanding communications.

162. At the November 23, 2007 visit, Respondent documented that an examination of the patient L.R.'s knees showed no looseness, no swelling, and that the patient was unable to flex more than 10 degrees, which appears to be a non-physiological finding. Respondent's documented impression is internal derangement of the knees with osteoarthritis. Respondent also noted scoliosis of the spine and his diagnosis of chronic pain syndrome. Respondent started the patient on #240 Vicodin ES, #240 Soma 350 mg., and 32 oz. Phenergan with codeine syrup and the patient was to return in four weeks.

163. On December 14, 2007, Respondent noted that patient L.R.'s x-rays were not done. The patient had pain in both of her knees, worse pain in the left knee. Respondent refilled her prescriptions: #240 Vicodin ES, #240 Soma 350 mg, and 32 oz. Phenergan with codeine syrup.

164. On January 11, 2008, Respondent's records indicate that patient L.R. reported that her purse was robbed, which included the x-ray report. The patient was wheezing and had a runny nose and reported her knee pain as 8/10. The patient also "used up her meds in 3 weeks." Respondent requested x-rays and increased the amounts prescribed to: #300 Vicodin ES, #300 Soma, and 32 oz. Phenergan with codeine cough syrup. The patient was to return in four weeks.

165. A February 7, 2008 report of bilateral knee x-rays for patient L.R. shows mild degenerative changes, which is not very suggestive of the significant knee difficulty described by the patient.

166. On February 8, 2008, Respondent's notes indicate that Respondent continues to "suspect" osteoarthritis in the patient's knees. Respondent prescribed: #300 Vicodin ES, #300 Soma 2350 mg, 32 oz. Phenergan with codeine cough syrup, and #120 Valium 10 mg..

167. On March 28, 2008, a portable chest x-ray for patient L.R. is read as normal.

168. On April 18, 2008, Respondent's records indicate that patient L.R. reported having fallen down stairs and that she was given an OxyContin that helped her. Respondent noted that his plan was to decrease the Vicodin and start OxyContin. Respondent prescribed #120

OxyContin, #120 Vicodin, #120 Valium 10 mg., #120 Soma 350 mg., and 32 oz. Phenergan with codeine cough syrup.

169. On May 16, 2008, Respondent notes that patient L.R.'s x-ray results were faxed and show mild degenerative changes in both knees. Respondent's documented plan is to wean the patient off of OxyContin and refer for an orthopedic consult. Respondent prescribed #60 OxyContin, #120 Vicodin ES, #120 Valium 10 mg., #120 Soma 350 mg., and 32 oz. Phenergan with codeine cough syrup. The patient was to return in four weeks.

170. On June 12, 2008, Respondent's records indicate that patient L.R. fell down three steps and had throbbing pain in her left ankle. She was advised to go to the Emergency Room. Respondent refilled her prescriptions times two and the patient was to return in four weeks.

171. On July 11, 2008 and on August 7, 2008, Respondent refilled patient L.R.'s monthly medications.

172. On October 17, 2008, Respondent's records indicate that he reviewed a CURES Patient Activity report for patient L.R. that shows that she received opiates from different physicians.

173. On October 31, 2008, Respondent's records indicate that he had L.R. sign a patient testimonial that she has not obtained pain medications from any other source. Respondent noted that when he asked L.R. about where she went in Arizona, she was unable to answer and that she left the office shouting that he was "going to die." Respondent does not document any prescriptions.

174. On December 11, 2008, Respondent notes that another patient (L.W.) accused patient L.R. of stealing his medications.

175. On December 17, 2008, Respondent notes that patient L.R. says that patient L.W. was lying about his medications and that she went to the pharmacy and "gave him the medications then & there." Patient L.R. and her sister reported that patient L.W. was abusing drugs and was stealing syringes from a blind diabetic and injecting medications. At this visit, L.R. said that she had gone to the hospital emergency room three times for her pain, that over-the-counter

medications are not helping and that she was told at the ER that she has gout. Respondent does not document any prescriptions.

176. On January 15, 2009, Respondent saw patient L.R. who complained of pain at the bottom of her feet and at her ankles. She reported being treated for gout by another physician. Respondent does not document any prescriptions.

177. On February 11, 2009, Respondent notes that patient L.R. will have carpal tunnel surgery, a complaint and diagnosis which Respondent did not document in any of the prior visits. Respondent refilled her medications: #60 OxyContin, #120 Vicodin ES, #120 Soma, and 32 oz. Phenergan with codeine cough syrup.

178. On March 11, 2009, Respondent notes that patient L.R. had terrible wheezing, had asthma in the past that required steroids, and that she did not really know when to take her medications. Respondent refilled her medications: #60 OxyContin, #120 Vicodin ES, #120 Soma, and 32 oz. Phenergan with codeine cough syrup.

179. On March 14, 2009, Respondent's records indicate that patient L.R. reported that her purse was stolen with the prescriptions in it. Respondent also noted that he received a report from a pharmacy that someone presented a prescription to fill for L.R. that had changed the amount of OxyContin to #160.

180. On April 1, 2009, Respondent noted patient L.R.'s story about her purse being stolen with the prescription in it and a report from the pharmacy that a recent prescription for her had been altered, which makes him think that he might be the subject of deception. Respondent gave L.R. a list of names of other pain management doctors.

181. Respondent's overall conduct, acts and/or omissions, with regard to patient L.R., as set forth in paragraphs 160 through 180 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and medical indication, pursuant to Business and Professions Code sections 2234 subdivisions (b) and/or (d) and/or 2242, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient L.R. as follows:

a. Respondent failed to obtain and document informed consent from patient L.R.

b. Respondent failed to conduct an adequate history and physical examination, and failed to adequately assess the patient's psychological functioning.

c. Respondent failed to conduct periodic review of the patient, such as obtaining random urine drug screens and/or a CURES patient activity report, which alone constitutes an extreme departure from the standard of care.

d. Respondent prescribed Vicodin, Soma, Valium, and Phenergan with codeine cough syrup to patient L.R. without a substantiated medical diagnosis and/or medical indication to support prescribing each of these medications, which constitutes extreme departures from the standard of care for each prescription.

e. Respondent failed to tailor his pharmacological treatment to treat the diagnosis of "internal derangement of knees with osteoarthritis" and failed to respond to physical examination findings that did not match the patient's pain complaints.

f. Respondent demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology in his acts and omissions with regard to patient L.R.'s treatment, which includes, for example, but is not limited to: (1) he started the patient at excessively high levels of Vicodin ES and Soma, (2) on 4/18/2008 he prescribed an incorrect titration of opiates, (3) he failed to take action when first learned patient was getting opiates from several different physicians, and (4) he prescribed Phenergan with codeine cough syrup to help the patient sleep.

g. Respondent failed to document a treatment plan.

h. Respondent failed to refer the patient to a physician specialist and/or failed to consult with other physicians about L.R..

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. L.W.)

182. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) and/or 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to patient L.W. constitutes gross negligence and/or incompetence and/or prescribing

without an appropriate prior examination and a medical indication, as more fully described herein below.

183. On February 8, 2008, Respondent saw patient L.W., a 52-year-old male, who complained of mid-back and shoulder pain. The patient reported a past medical history that included lye damage to his esophagus, that he used to smoke marijuana until 2 or 3 years ago, and that he now drinks 2 or 3 cans of beer two or three times a month but has not been drunk for 20 or 30 years. Patient L.W. reported that he was arrested 15 years ago for petty theft and spent one week in jail. Respondent's examination showed a scar over the shoulder and impingement signs, decreased range of motion in the neck and back. Respondent's impression was failed left shoulder surgery and cervical and lumbar spondylosis. Respondent prescribed: #60 MS Contin 200 mg., #240 Vicodin ES, #180 Soma 350 mg., #30 Lidoderm patches, #120 Valium 10 mg., and 16 oz. Phenergan with codeine syrup. There is a notation that the prescription for MS Contin was lost and that another separate prescription was given.

184. On March 7, 2008, Respondent noted that patient L.W. was not working and was temporarily living with a friend. The patient stated that he had a psychiatrist and had bipolar disorder and was on Seroquel, which he did not take regularly. Respondent refilled patient L.W.'s medications and issued separate prescriptions for #60 MS Contin and #240 Vicodin ES.

185. On April 11, 2008, Respondent noted that patient L.W. was arrested on 3/26/2008 for loitering, had someone else's ID on him, was incarcerated for sixteen days, and was now on probation. Patient L.W. stated that he had taken OxyContin from a friend and felt improvement. Respondent prescribed #60 OxyContin 80 mg., #240 Vicodin ES, #180 Soma 350 mg., #120 Valium, and 32 oz. Phenergan with codeine syrup.

186. On May 16, 2008, Respondent refilled patient L.W.'s prescriptions and increased the amount of OxyContin: #120 OxyContin, #240 Vicodin ES, #180 Soma, #120 Valium, and 32 oz. Phenergan with codeine cough syrup. The patient was to return in four weeks.

187. On July 25, 2008, Respondent noted that patient L.W. said that he burnt himself while barbecuing and that he ran out of medicine a week or two ago when he took extra medication for his burn injury. Respondent gave the patient early refills on his prescriptions.

188. On July 30, 2008, Respondent's records indicate that patient L.W. was kept in a mental health facility for two days because of mood swings and was given Seroquel and Trazodone. Respondent refilled the patient's prescriptions: #60 OxyContin, #240 Vicodin ES, #180 Soma, #120 Valium, and 32 oz. Phenergan with codeine cough syrup.

189. On August 22, 2008, Respondent filled patient L.W.'s medications with two refills, including #240 Vicodin ES, #240 Tylenol No. 4, #200 Soma 35 mg., 32 oz. Phenergan with codeine cough syrup. This is a toxic level of acetaminophen.

190. On November 12, 2008, Respondent refilled patient L.W.'s prescriptions: Vicodin ES, Soma, and Phenergan with codeine syrup.

191. On December 2, 2008, Respondent noted that patient L.W. claimed that patient L.R. picked up his prescriptions but did not give them to him.

192. On December 11, 2008, Respondent noted that he called the pharmacy to make sure that only patient L.W. received his prescriptions.

193. On December 17, 2008, Respondent noted that patient L.R. said that patient L.W. was dealing prescriptions and stealing syringes, that she handed him her prescriptions, and that he uses street drugs. Respondent also noted that L.W. failed to keep numerous appointments and that he will terminate his service.

194. On January 7, 2009, Respondent noted that patient L.W. had no signs that he is "shooting drugs" and that the patient reported going to church twice a week. Respondent prescribed #240 Vicodin ES and #240 Tylenol No. 4 plus #200 Soma and 32 oz. Phenergan with codeine cough syrup. This is a toxic level of acetaminophen.

195. On January 23, 2009, Respondent's records indicate that the patient was in pain and that he refilled an emergency prescription of #180 Vicodin and 32 oz. of Phenergan with codeine syrup.

196. On February 4, 2009 (less than two weeks later), Respondent's records indicate that patient L.W. stated that he is staying with his sister and that he has a girlfriend who is going to help him get a job. Respondent prescribed: #180 Norco 10/325, #240 Tylenol No. 4, #240

Vicodin ES, #240 Soma, and 32 oz. Phenergan with codeine syrup. This is a toxic level of acetaminophen.

197. On both March 4, 2009 and March 27, 2009, Respondent refilled patient L.W.'s medications. These include toxic doses of acetaminophen.

198. On April 24, 2009, Respondent's records indicate that patient L.W. admitted to smoking marijuana and said that he ran into a doorknob when being chased by another man over a woman. Patient L.W. made grandiose statements about being a ladies' man. Respondent increased the amount of Norco by twenty pills and refilled the prescriptions. This is a toxic level of acetaminophen.

199. On May 22, 2009, June 12, 2009, July 10, 2009, and August 4, 2009, Respondent documented refilling patient L.W.'s prescriptions, which are toxic levels of acetaminophen.

200. On September 4, 2009, Respondent refilled patient L.W.'s medications, including #320 Norco, #240 Vicodin, #120 Valium, #200 Soma, and 48 oz. Phenergan with codeine syrup. This is a toxic level of acetaminophen.

201. On September 9, 2009, Respondent's records indicate that patient L.W.'s mental state was confused and that he was hospitalized and kept overnight and then taken to a police station. Respondent refilled the patient's prescriptions: #320 Norco, #240 Vicodin ES, #120 Valium, #200 Soma, and 48 oz. Phenergan with codeine syrup. This is a toxic level of acetaminophen.

202. On October 7, 2009, Respondent's records indicate that he refilled patient L.W.'s medications: #320 Norco, #240 Vicodin ES, #120 Valium, #200 Soma, 48 oz. Phenergan with codeine, and #60 MS Contin 100 mg.. The patient was to return in four weeks.

203. Two weeks later, on October 14, 2009, Respondent noted that patient L.W. said that his medications were stolen. Respondent prescribed #120 OxyContin 80 mg. and an unknown amount of Tylenol No. 4.

204. Another two weeks later, on October 30, 2009, Respondent noted that he refilled patient L.W.'s medications, including #120 OxyContin, #320 Norco, #240 Vicodin ES, #200 Soma 350 mg., #240 Tylenol No. 4, and 48 oz. Phenergan with codeine syrup. This is a toxic level of acetaminophen.

205. On January 8, 2010, Respondent's records indicate that patient L.W. stated that he fell and injured his right shoulder. Respondent noted that it was hard to evaluate the patient's complaint. Respondent gave patient L.W. three months of prescription medications and told him to find another physician. Respondent did not document further the reasons for his termination of care for this patient.

206. Respondent's overall conduct, acts and/or omissions, with regard to patient L.W., as set forth in paragraphs 182 through 205 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and medical indication, pursuant to Business and Professions Code sections 2234 subdivisions (b) and/or (d) and/or 2242, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient L.W. as follows:

a. Respondent failed to obtain and document informed consent from patient L.W.

b. Respondent failed to conduct an adequate history and physical examination and failed to adequately assess the patient's psychological functioning.

c. Respondent failed to conduct periodic review of the patient, such as obtaining random urine drug screens and/or a CURES patient activity report, which alone constitutes an extreme departure from the standard of care.

d. Respondent failed to refer this patient to another pain specialist and/or a psychiatrist for treatment and/or failed to consult with other physician specialists about the patient's care and treatment. Respondent accepted treatment of this patient who had psychological problems and admitted to not taking his anti-psychotic medications, who had a history of an attempted suicide, jail time, and a poly-substance problem. Based on his history and condition, patient L.W. should not have been treated in a solo practice by Respondent. Respondent's failure to refer the patient to another practice for treatment constitutes an extreme departure from the standard of care.

e. Respondent treated L.W. with large doses of controlled substances for unsubstantiated complaints of patient L.W., who was homeless and delusional, without a

documented physical examination and objective findings to support a medical diagnosis and/or a medical indication.

f. Respondent's pharmacological treatment was likely detrimental to the patient. The amount of acetaminophen prescribed to patient L.W. was above the maximum acceptable daily dose. There is no indication in the records that Respondent warned patient L.W. of the hazard of taking an over-the counter-medication containing acetaminophen, which would move him deep into the toxic range and be potentially fatal, causing liver failure.

g. Respondent demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology in his acts and omissions with regard to patient L.W.'s treatment, which includes, for example, but is not limited to: (1) he failed to recognize that he prescribed a toxic and inherently dangerous level of acetaminophen by consistently prescribing a toxic dose of acetaminophen, more than 4 grams daily, between February 4, 2009 and through October 30, 2009, (2) he prescribed Phenergan with codeine cough syrup to help the patient sleep, and (3) he called in early refills and even increased the amounts of the medication without any medical indication.

h. Respondent failed to take action when the patient appeared to be delusional. Respondent also failed to act after the patient admitted to illicit drug use, and after the patient's claims of lost prescriptions and of pharmacy mix-ups.

i. Respondent failed to document a treatment plan.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. D.C.)

207. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) and/or 2242 in that Respondent's overall conduct, acts and/or omissions, with regard to patient D.C. constitutes gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

208. On September 11, 2008, patient D.C., an 81-year-old male retired construction and shipyard worker, saw Respondent with a complaint of left leg pain following a gunshot wound

three years ago. Respondent documented a history and physical and asked about history of drug and alcohol abuse. Respondent noted that the patient appeared to be mildly demented. Patient D.C. said that he had spent time in jail. Respondent noted that the patient's prior pain treatment history was difficult to obtain because the patient was a poor historian. Respondent diagnosed a gunshot injury to the left lower extremity, cervical and lumbar spondylosis, and diabetic neuropathy. Respondent noted that patient D.C. tended to fall and that he had a tremor. Respondent prescribed #240 Vicodin ES, #240 Tylenol No. 4, #120 Valium 10 mg., #240 Soma, Valium, 32 oz. Phenergan with codeine cough syrup, and #60 Cymbalta 60 mg..

209. On October 10, 2008, Respondent saw patient D.C. who said that the Cymbalta did not help his numbness and leg pain. Respondent prescribed Vitamin B12 and the following: #60 OxyContin, #240 Vicodin ES, #240 Tylenol No. 4, #240 Valium 10 mg., #120 Soma 350 mg., Valium, 32 oz. Phenergan with codeine cough syrup.

210. On November 7, 2008, patient D.C. reported the pain in his legs at worst was 10/10. Respondent does not document any physical examination. Respondent prescribed #120 MS Contin, #240 Norco 10/325, #180 Soma 350 mg., #90 Tylenol No. 4, and 32 oz. Phenergan with codeine cough syrup.

211. On January 30, 2009, patient D.C. reported that he never got the OxyContin or the MS Contin. He said that the pain in his legs at worst was 5/10 and at best 0/10. Respondent does not document any physical examination. Respondent prescribed #240 Vicodin ES, #240 Tylenol No. 4, #240 Soma 350 mg., #240 Valium, and 32 oz. Phenergan with codeine cough syrup.

212. On April 17, 2009, patient D.C. reported doing better and asked for OxyContin. Respondent does not document any physical examination. Respondent prescribed #60 OxyContin 80 mg. and refilled the other medications, and issued sequential prescriptions for 5/15/2009 and 6/12/2009.

213. On July 10, 2009, patient D.C. reported having diabetes. Respondent does not document any physical examination. Respondent prescribed #60 OxyContin, #240 Vicodin ES, #240 Tylenol No. 4, #240 Soma, #180 Valium, and 32 oz. Phenergan with codeine cough syrup. Respondent issued sequential prescriptions for 7/10/2009, 8/07/2009 and 9/04/2009.

214. On October 2, 2009, Respondent noted that patient D.C. does not comprehend the pain scale and that he prefers Norco over Vicodin ES. Respondent refilled the patient's medications from July 10 except he switched Norco for Vicodin ES. Respondent issued sequential prescriptions for 10/02/2009, 10/30/2009, and 11/27/2009.

215. Respondent's overall conduct, acts and/or omissions, with regard to patient D.C., as set forth in paragraphs 207 through 214 herein, constitutes unprofessional conduct through gross negligence and/or incompetence and/or prescribing without an appropriate prior examination and medical indication, pursuant to Business and Professions Code sections 2234 subdivisions (b) and/or (d) and/or 2242, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient D.C. as follows:

a. Respondent failed to obtain and document informed consent from patient D.C.

b. Respondent failed to conduct an adequate history and physical examination.

c. Respondent failed to conduct periodic review of the patient, such as obtaining random urine drug screens and/or a CURES patient activity report.

d. Respondent failed to take actions on the objective findings that suggested a neurological disease. Respondent failed to refer this patient to a neurologist or other pain specialist and/or failed to consult with other physician specialists about the patient's care and treatment.

e. Respondent's pharmacological treatment was poorly tailored to the patient's needs and was likely detrimental to the patient. Respondent demonstrated a lack of knowledge and a lack of understanding of basic medical science and pharmacology in his acts and omissions with regard to patient D.C.'s treatment, which includes, for example, but is not limited to: (1) he failed to recognize that a starting dose of 60 mg. of Cymbalta is not generally well-tolerated in an older man, (2) he prescribed Soma, Valium and Phenergan with codeine when all decrease cognitive functioning, (3) he prescribed Phenergan with codeine cough syrup to help the patient sleep, (4) he failed to recognize that Soma, Valium and Phenergan all decrease cognitive functioning in a patient exhibiting signs of dementia; (5) he prescribed OxyContin and/or Vicodin ES in high doses without a medical indication; and, (6) he failed to recognize that adverse events

may be expected from such a medication regimen for a patient who is already at increased risk for a fall.

f. Respondent failed to document a treatment plan.

TENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. G.B.)

216. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) in that Respondent's overall conduct, acts and/or omissions, with regard to patient G.B. constitutes gross negligence and/or incompetence, as more fully described herein below.

217. Patient G.B., a 55-year-old male, was first seen on August 13, 2003, at Redwood Rehab Medical Group, Inc., the clinic in which respondent was employed, with chronic back, knee and foot pain. The initial evaluation was done by another physician and included a complete history, review of systems, and physical exam. G.B. completed a health questionnaire in which he reported that he had Hepatitis C. G.B. signed a controlled substances contract. G.B. is married to patient D.S.

218. Later in August 2003, G.B. was sent to jail where he remained until January 22, 2004.

219. G.B.'s condition worsened in jail. He returned to the clinic on February 16, 2004 and saw respondent. He complained of low back pain with radiation to the left leg. By this time, progressive neurologic deficit had resulted in paraplegia. Respondent noted that G.B. was scheduled to see the neurologist two days later. He prescribed #180 Vicodin ES tablets, one every 4 to 6 hours; #180 Soma tablets, one every 4 to 6 hours; #90 Norco tablets, one every 4 to 6 hours; and #30 tablets of 10 mg Valium. Respondent did not obtain G.B.'s medical records from the jail or from any health care providers prior to G.B. presenting at Redwood Rehab Medical Group, Inc. in August 2003.

220. On G.B.'s next visit, three weeks later, on March 8, 2004, Respondent refilled his prescriptions for the same amounts. The amount of acetaminophen in #180 Vicodin ES and #90 Norco over a 21-day period averages approximately 7,928 mg per day.

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221. Again on April 1, 2004, Respondent refilled G.B.'s prescriptions for the same amounts. The amount of acetaminophen in #180 Vicodin ES and #90 Norco over a 24-day period averages approximately 6,937 mg per day.

222. On April 26, 2004, Respondent assessed G.B.'s pain level and ability to function and prescribed #90 Vicodin ES tablets, #180 Norco tablets, #240 Soma tablets, and #30 Valium tablets.

223. An MRI showed multilevel degenerative disc disease with spinal stenosis and on May 12, 2004, G.B. underwent a T10-11 decompressive laminectomy. G.B.'s discharge medications included #60 Norco tablets and #50 Soma tablets. Ultimately, the surgery failed to relieve G.B.'s pain.

224. G.B.'s next visit with Respondent and prescription refill was on May 24, 2004. Respondent saw G.B. monthly for evaluations and kept him on the same medications–increasing the amount of Valium from #30 to #60, then to #90 tablets–until November 24, 2004, when Respondent discontinued the Vicodin ES and added #90 tablets of Percocet. During this same time period, G.B. was seen by Ambulatory Care on May 27, June 24, and August 19, 2004, in follow-up to back surgery, at which times he was prescribed #90 Norco tablets, #40-#60 Vicodin tablets, and #60-#90 Soma tablets.

225. On January 17, 2005, Respondent added 16 oz. of Phenergan with codeine cough syrup to the rest of G.B.'s medications. On April 11, 2005, he increased the Percocet to #120 tablets and increased the Norco to #240 tablets. On June 6, 2005, he increased the Valium to #120 tablets.

226. G.B. was seen by Respondent on September 19, 2005, at which time he reported being hit by a car while in his wheelchair. Respondent examined G.B. and increased his Norco to #300 tablets. On October 17, 2005, respondent added #120 tablets of 10 mg Methadone to G.B.'s prescription medications. According to a Department of Justice Controlled Substance Utilization Review and Evaluation System (C.U.R.E.S.) Report and prescription profile from Civic Center Pharmacy in Richmond, CA, G.B. had been getting #125 to #135 tablets of 10 mg Methadone

nearly every month from December 1, 2004, through November 4, 2005, from his primary care physician. Respondent did not document these prescriptions in his chart notes.

227. On February 2, 2006, Respondent increased G.B.'s Soma to #300 tablets and his Valium to #180 tablets. On March 2, 2006, Respondent discontinued Percocet and increased the Methadone to #240 tablets. On March 31, 2006, Respondent gave G.B. a recommendation for medical marijuana and increased his Phenergan with codeine cough syrup to 32 oz.

228. In December 2006, Respondent increased G.B.'s Valium prescription to #200 tablets and his Methadone to #300 tablets. G.B.'s medication remained the same until approximately August 2007, when Respondent added a 100 microgram Duragesic patch to be changed every three days. On March 28, 2008, Respondent discontinued the Duragesic patch and on April 25, 2008, he increased the Valium to #300 tablets.

229. On May 23, 2008, Respondent noted that G.B.'s present program was working well and that he would be able to do sequential prescriptions in the future. On June 20, 2008, Respondent scheduled a return visit for G.B. on September 12, 2008, and charted sequential refills of G.B.'s prescriptions in the interim for July 18, August 15, and September 12, 2008.

230. Respondent's overall conduct, acts and/or omissions, with regard to patient G.B., as set forth in paragraphs 216 through 229 herein, constitutes unprofessional conduct through gross negligence and/or incompetence, pursuant to Business and Professions Code sections 2234 subdivisions (b) and/or (d), and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient G.B. as follows:

a. Respondent failed to obtain medical records of G.B.'s prior treatment.

b. Respondent failed to refer G.B. to an addiction specialist in light of the C.U.R.E.S. Report showing that he had received prescriptions for controlled substances from another prescriber and in light of G.B.'s risk factors (Hepatitis C and having been jailed for drug abuse.)

c. Respondent prescribed potentially lethal doses of acetaminophen for G.B. and used unconventional combinations of controlled substances at high doses.

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ELEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Incompetence re Pt. D.S.)

231. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(d) in that Respondent's overall conduct, acts and/or omissions, with regard to patient D.S. constitutes gross negligence and/or incompetence, as more fully described herein below.

232. Patient D.S., a then 55-year-old woman, was first seen on July 30, 2003, at Redwood Rehab Medical Group, Inc. with complaints of neck, leg, and low back pain. The initial evaluation was done by another physician and included a complete history, review of systems, and physical exam. She was diagnosed with osteoarthritis of both knees, lumbo sacral strain with degenerative disc disease, and shoulder pain. D.S. reported a history of scoliosis as a child, surgery on her rotator cuff (1990), hypertension, congestive heart failure, and replaced mitral valve in 1999. D.S. completed a health questionnaire in which she reported that she had Hepatitis. D.S. is married to patient G.B.

233. At this first visit to the clinic on July 30, 2003, D.S. was prescribed Motrin 800 to be taken three times a day, #240 tablets of Norco, #120 tablets of Soma, and #30 tablets of 25 mg Elavil. The records reflect that D.S. reported that she also used Percocet which she obtained from street sources. The initial treating physician noted in the physician progress report for D.S.'s second visit on August 13, 2003, that D.S. had an "addictive personality."

234. Respondent assumed D.S.'s care on September 10, 2003. He documented a physical examination, assessed D.S.'s pain level and ability to function, and continued her prescriptions, reducing the Motrin 800 to twice a day. Neither the initial treating physician at the clinic nor Respondent obtained D.S.'s prior medical records and neither documented a strategy to deal with D.S.'s addiction potential or a referral to a substance abuse expert. Despite the fact that D.S. was being prescribed controlled substances, neither the initial treating physician at the clinic nor respondent obtained an informed consent and treatment agreement from D.S.

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235. On October 8, 2003, Respondent replaced D.S.'s Elavil with #90 Valium 10 mg. tablets. On October 29, 2003, he prescribed #120 tablets of Percocet, reduced the Norco to #90 tablets, increased the Soma to #180 tablets, and continued the #90 tablets of Valium.

236. On November 19, 2003, D.S. claimed that she had not filled her Percocet prescription. Respondent prescribed #90 tablets of Motrin 800, #180 of Norco, #100 of Valium, and #180 of Soma. On December 12, 2003, Respondent discontinued the Motrin 800, and on February 16, 2004, he increased Norco to #200 tablets.

237. On May 24, 2004, respondent prescribed #90 tablets of Roxicet, #200 tablets of Norco, #90 tablets of Valium, and #180 tablets of Soma. On August 16, 2004, Respondent replaced the Roxicet with Percocet, #90 tablets. On November 1, 2004, he added 16 oz. of Phenergan with codeine cough syrup. On January 17, 2005, Respondent increased the Percocet to #120 tablets. According to a Department of Justice C.U.R.E.S. Report, in 2005, D.S. was filling prescriptions from a physician other than respondent for hydrocodone with acetaminophen (Norco). Respondent did not document these prescriptions in his chart notes.

238. On April 11, 2005, Respondent evaluated D.S.'s pain level and functioning and prescribed #120 tablets of Percocet, #240 tablets of Soma, #120 tablets of Valium, #240 tablets of Norco, and 16 oz. of Phenergan with codeine cough syrup.

239. On September 19, 2005, D.S. reported that she was struck by a car and knocked onto G.B. and his wheelchair. Respondent increased D.S.'s Norco to #300 tablets and added #120 tablets of 10 mg Methadone on October 17, 2005. According to a Department of Justice C.U.R.E.S. Report, D.S. had gotten #180 tablets of 10 mg Methadone in August, September, October, and November 2005 from another physician. Respondent did not document these prescriptions.

240. On February 2, 2006, Respondent increased D.S.'s Valium to #180 tablets, increased her Soma to #300 tablets, and increased her Phenergan with codeine cough syrup to 32 oz. On March 2, 2006, he discontinued the Percocet and increased D.S.'s Methadone to #240 tablets.

241. On March 31, 2006, Respondent gave D.S. a recommendation for medical marijuana.

242. On August 18, 2006, Respondent increased D.S.'s prescription for Valium to #200 tablets and on November 10, 2006, he increased her prescription for Methadone to #300 tablets. Respondent continued seeing D.S. monthly, evaluating her pain levels and functioning, and prescribing the same amounts of Valium (#200 tablets), Norco (#300 tablets), Soma (#300 tablets), Methadone (#300 tablets), and Phenergan with codeine cough syrup (32 oz.) through June 20, 2008.

243. Respondent's chart notes for April 18, 2008, reflect that respondent was notified that D.S. tested positive for cocaine use twice while hospitalized for a rectal ulcer. No discussion with D.S. of these test results was documented. On June 20, 2008, Respondent scheduled a return visit for D.S. on September 12, 2008, and charted sequential refills of D.S.'s prescriptions in the interim for July 18, August 15, and September 12, 2008.

244. Respondent's overall conduct, acts and/or omissions, with regard to patient D.S., as set forth in paragraphs 231 through 243 herein, constitutes unprofessional conduct through gross negligence and/or incompetence, pursuant to Business and Professions Code sections 2234 subdivisions (b) and/or (d), and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to patient D.S. as follows:

a. Respondent failed to obtain medical records of D.S.'s prior treatment;

b. Respondent failed to document a strategy to deal with D.S.'s addiction potential which could include referral to a substance abuse expert, regular urine drug testing, and avoiding an increase in opioid dosing;

c. Respondent failed to refer D.S. to an addiction specialist in light of the C.U.R.E.S. Report showing that she had received prescriptions for controlled substances from other prescribers, her obtaining Percocet from the streets, and her two positive cocaine tests;

d. Respondent failed to have an informed consent and treatment agreement;

e. Respondent prescribed unconventional combinations of controlled substances at high doses for D.S.

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TWELFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Excessive Prescribing)

245. Respondent is subject to disciplinary action for unprofessional conduct under section 2234 and section 725 for excessive prescribing of controlled substances as alleged in paragraphs 26 through 244 which are incorporated herein by reference as if fully set forth. Respondent's excessive prescribing includes, but is not limited to, the prescribing of toxic levels of acetaminophen and the chronic prescribing of Phenergan with codeine cough syrup, as described herein and below.

Prescribing Acetaminophen At Toxic Levels

246. The current standard of care for prescribing acetaminophen is to prescribe no more than 3- 4 grams daily of acetaminophen, with 4 grams being the outermost daily limit. For patients who have a history of alcohol abuse, the standard of care is to prescribe no more than 2 grams of acetaminophen daily. This is because large doses of acetaminophen are known to cause liver damage and have the potential for being fatal. Acetaminophen is a component in many over-the counter remedies and in these controlled substances, among others: Norco, Vicodin, and Tylenol No. 4 with codeine.

247. In his interviews with the Medical Board, Respondent stated that Tylenol (a trade name for acetaminophen) is non-toxic for chronic users, which is scientifically incorrect. He believes that there is no maximum limit of dosing for acetaminophen to chronic pain patients. He erroneously interpreted recent studies to support his position that 10 grams a day of acetaminophen is perfectly safe.

Prescribing Phenergan With Codeine Cough Syrup For Sleep

248. Respondent prescribed Phenergan with codeine syrup to all eleven patients alleged herein. In his interview with the Medical Board, Respondent stated that he always prescribed Phenergan with codeine to help his patients sleep.

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THIRTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts)

249. In the alternative, Respondent is subject to disciplinary action for unprofessional conduct under section 2234(c) for repeated negligent acts with regard to his acts and/or omissions as alleged in paragraphs 26 through 248 which are incorporated herein by reference as if fully set forth.

FOURTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Inadequate Record Keeping)

250. Respondent is subject to disciplinary action for unprofessional conduct under section 2266 for failure to maintain adequate and accurate records relating to the provision of services to his patients, as alleged in paragraphs 26 through 248 which are incorporated herein by reference as if fully set forth.

SUPPLEMENTAL JURISDICTION

251. Business and Professions Code section 2238 states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

252. Health and Safety Code section 11157 states: "No person shall issue a prescription that is false or fictitious in any respect."

253. Health and Safety Code section 11172 states: "No person shall antedate or postdate a prescription."

254. Health and Safety Code section 11173 provides, in pertinent part:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

"(b) No person shall make a false statement in any prescription, order, report, or record, required by the division. . . . "

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FIFTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Dishonest or Corrupt act; False Prescription; Post-dated prescription)

255. Respondent is subject to disciplinary action for unprofessional conduct under section 2234 and/or under 2234(e) for dishonest or corrupt acts and/or through 2238 for violations of Health and Safety Code sections 11157, 11172, and/or 11173 regarding the issuing of a false and/or post-dated prescription of controlled substances, the circumstances of which are more fully described herein below.

256. On or about April 13, 2010, a man presented at Bacon East Pharmacy in Concord with a prescription dated March 31, 2010 that was written by Respondent for patient KM. The prescription was for #360 Oxycontin 80 mg. and the directions were to take 6 tablets every 12 hours. It was minutes before the pharmacy was to close for the evening. The pharmacist tried to reach Respondent to verify the validity of the prescription but was not able to reach him. The man stated that the prescription was for his uncle who was terminally ill. The prescription was filled and was paid for by cash in the amount of $4,681. The next day, the pharmacist spoke with Respondent by telephone to verify the prescription and Respondent told him that patient KM died on February 23, 2010, and that he (Respondent) had "predated" the prescription because the patient was terminally ill and was suicidal.

SIXTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Dishonest or Corrupt acts; Violations of the ISO; False Prescriptions; and/or Ante- or Post-dated prescriptions)

257. Respondent is subject to disciplinary action for unprofessional conduct under section 2234 and/or under 2234(e) for dishonest or corrupt acts and/or under 2238 through violations of Health and Safety Code sections 11157, 11172, and/or 11173 for violating the terms of the Interim Order of Suspension, effective April 5, 2011, which prohibits Respondent from prescribing controlled substances, and for writing false and/or ante-dated or post-dated prescriptions of controlled substances, the circumstances of which are more fully described herein below.

258. On April 13, 2011, Respondent wrote a prescription for one patient (A) for #180 tablets of Methadone 10 mg, which was presented and filled at a Medicap Pharmacy in Pleasanton.

259. On April 15, 2011, Respondent wrote the following three prescriptions for one patient (B), which were presented and filled at a Rite Aid Pharmacy in Antioch:

a. Prescription for #300 tablets of Dilaudid 8 mg.

b. Prescription for #300 tablets of Methadone 10 mg.

c. Prescription for #300 tablets of Oxycontin 80 mg.

260. On April 16, 2011, Respondent faxed to Express Scripts a prescription order dated April 5, 2011 for patient (C) with the following two prescriptions:

a. Prescription for #300 tablets of Norco 10/325, with 12 refills.

b. Prescription 60 (or 80) oz. Promethazine with Codeine cough syrup, with 12 refills.

261. On April 18, 2011, Respondent faxed to Express Scripts a prescription order dated March 30, 2011 for that same patient (C) with the following three prescriptions:

a. Prescription for #500 tablets of Oxycodone 30 mg.

b. Prescription for #300 tablets of Norco 10/325.

c. Prescription for 80 oz. Phenergan with Codeine cough syrup.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 17929, issued to Edward Manougian, M.D.;

2. Revoking, suspending or denying approval of Edward Manougian, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Edward Manougian, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and/or

4. Taking such other and further action as deemed necessary and proper.

DATED: January 9, 2012

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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